ALASKA HEALTH CARE COMMISSION

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P R O C E E D I N G S

8:06:32

(On record)

CHAIR HURLBURT: Welcome, everybody, again this morning. Today, we're going spend most of the morning, our biggest section, with the update on behavioral health, as I think most of all of us would remember, this is a very significant component of the challenges that we face. It's very much related to the kind of integrated care that is being looked at that we heard about where this facility, for example, is contracting with South Central for some help moving toward the Nuka model that was developed there at South Central, but we have elected, since there are other groups, particularly looking at the behavioral areas, this is one of the areas that we want to keep informed on and knowledgeable about, but not the one that we address as much as we've been talking about issues related to cost related to overall quality and so on.

So we have three folks who will be with us this morning; Al Wall, who's the Director of the Division of Behavioral Health in the Department of Health and Social Services, Kate Burkhart, who will be joining us, Executive Director of the Alaska Mental Health Board and the Advisory Board on Alcoholism and Drug Abuse, and Suicide Prevention Council, and Thomas Chard, the Executive Director of the Alaska Behavioral Health Association and.....

MS. ERICKSON: And we actually have a fourth person joining us for the presentation, who didn't make it on the agenda. I'll adjust the agenda later to make sure, but somebody who is with the Behavioral Health Program at Alaska Native Tribal Health Consortium is also going to participate in the presentations this morning.

CHAIR HURLBURT: Okay.

MS. ERICKSON: I just wanted to mention that.

CHAIR HURLBURT: And Al was here.

UNIDENTIFIED SPEAKER: He just stepped out (indiscernible - too far from microphone).

MS. ERICKSON: He's still here.

CHAIR HURLBURT: Al, I just introduced you and gave the little background that -- the posture and the role that the Commission's played in regard to behavioral health is because there are other groups looking at that, that we have had this and other presentations to kind of keep us informed of what's going on, but it has not been as focused an area related to recommendations and so on, as some of the cost issues and other issues there.

So Al, I appreciate you coming and joining us today and I guess we'll have your other colleagues here now. So if you could go ahead and.....

MS. ERICKSON: Well, we're going to spend a little time -- they weren't going to start until 8:30.

CHAIR HURLBURT: Okay, so you -- go ahead.

MS. ERICKSON: So yeah (affirmative), so I can go ahead and take over and we.....

CHAIR HURLBURT: I misunderstood. When you said, "Go ahead," I thought that's what you meant. I'm so sorry.

MS. ERICKSON: No, I'm sorry. No, I just meant go ahead with the meeting.

CHAIR HURLBURT: Yeah (affirmative).

MS. ERICKSON: So.....

CHAIR HURLBURT: But stay where you are, Al.

MS. ERICKSON: You can and.....

MR. WALL: Standing by.

MS. ERICKSON: So we'll start and have the behavioral health session starting at 8:30 on our agenda, and what we've gotten in the practice of doing is just spending a little bit of time the morning after our first full day with reflecting back on any particular learnings from the day before, what your take-aways might have been from the day before, after you had an evening to process a little bit.

We've focused on that and provided more time for that in the past around when we've had sessions where we're going to be developing findings or recommendations, it will be official findings or recommendations of the Commission. So we're not spending as much time on that, but I still wanted to give you all an opportunity. There's a lot of -- we focused on

learning sessions in this meeting and so there's been a lot of sitting and listening for you all.

I wanted you to have a chance to have a conversation about your experience yesterday and if -- what you felt you would take away from those sessions. So I'm just going to open it up just like the normal brainstorming and capture some of your thoughts and some -- that's just for our meeting notes. So whoever would want to go first.....

COMMISSIONER URATA: I'm impressed with the facilities that the VA and JBER have. I think that there may be a shortage of services for minimal traumatic brain injuries in the private sector, but they've got something good going here in Anchorage in the VA, in the joint program.

COMMISSIONER STINSON: I concur with Dr. Urata. I would add in, I think they have worked out some of the more difficult details of telemedicine and that is something that could be encouraged and I think, particularly, if you have another clinical trained person in the room with the patient, that should ease some of the previous thoughts about not actually doing a physical examination on the patient, because you are, and then another thing I was going to just point out was for the sanitation and the clean water, that came through how absolutely important that was and what an impact it has on health, but the daunting task of making it work out in small villages with a dollar amount and I really hope they find

something innovative from Scandinavia or Russia or some other place because the dollar amount that goes with that is impressive.

COMMISSIONER ENNIS: I was impressed with the TBI clinic or setting, as well, and especially found that the alternative modalities that we're using, acupuncture, yoga, the -- even the furniture that was selected was most interesting and again, impressive that they had incorporated so much of alternative strategies in the setting.

COMMISSIONER CAMPBELL: I guess what really surprised me was the numbers of people that facility handles in the year. It had, you know, as a GI, I've never had to take advantage of stuff like that, but it's kind of comforting knowing that it's there and it's -- I mean, I just was blown away by the total number of people in this state who utilize that facility.

CHAIR HURLBURT: I was impressed with the innovativeness and the way the technology was being used for primary care in the telemedicine be -- but the reason they were doing it was because they have been unable to hire primary care physicians here in Anchorage and I'm at one end of the spectrum and in my own mind is -- the question is, why would you want to live in Florida when you could live in Anchorage, but the reality is that you can't turn on your television here and you can't look at the newspaper without seeing advertisements for primary care physicians and so there must be capacity.

I asked Susan if she felt it was a noncompetitive issue, in terms of compensation, and she didn't feel -- her perception was that it was not. Government salaries are public. I asked her what they would start a brand new family medicine resident at, just hiring them right out of residency and she said about 175, which seems like, at least from what family medicine graduates would make elsewhere in the country, should be competitive and enough to attract people.

MS. ERICKSON: Should be competitive.

CHAIR HURLBURT: So I ended up kind of -- while the technology and the innovativeness in addressing a difficult problem that they had was impressing, I still ended up wondering why -- why they have to do it.

Bob, did you have any different take on that? I know you were impressed with the technology and you're more of a nerd than I am, but I meant it as a compliment, but from a primary care setting, what was your take on that?

COMMISSIONER URATA: Well, I was impressed with their primary care. Although, I, you know, we didn't really see a whole lot of activity or how things really work in action. I'm not sure why they're having a hard time getting primary care because it seems to me, that you know, like in Juneau, we're doing pretty well and we actually pay less, you know, we start out at $12,000 a month for a brand new grad and we've been able to attract one person that way, but I think the

demand is going up. So we're going to have to start paying more, but one of the things is, that you know, all of the people that we talk to or interview, you know, for a position, at least a couple of years ago, they all have a lot of debt, you know.

UNIDENTIFIED SPEAKER: What?

COMMISSIONER URATA: Debt, loans to pay back, $80,000 to $150,000 in one case or somewhere in there, and so some of them are looking for, you know, I've got to get out of debt right away. I want to get the most money I can have, and stuff like that. The other thing to look at is, you know, what's the long-term thing for the VA, you know, how much advancement and increase in salary? Is it once a year, twice a year, and then the workload, and so we're pretty generous, you know, you get a month off and then you get two weeks off, two more weeks off for educational, and then we pay for your educational or we give you a certain amount of money for educations stipend and stuff and then you get to work with us and we try to make it look like it's going to be a lot of fun and stuff, but once they get started, they have to work their butts off.

So -- so you know, it might be different, you know, like in private practice, you have more control, and so -- but in the VA, you know, it's a big system. So you have, you know, there's a lot of people above you that you have to be under

for a while before you can work your way up the chain of command, so maybe some of those things, but I don't really know.

CHAIR HURLBURT: Yeah (affirmative), it -- Susan said their panel size was 1,250 and then she had to caveat that nobody's there yet, that we're building up to that. My own experience with employed physicians, at least in a private company, was that we were pushing 1,800 to 2,000, and able to do that with a reasonable lifestyle, with a month vacation a year and maintain access and some people who wanted to work harder, could carry more with good quality, but -- and the reason I asked about the age is we gave three for one credit if you're 65 or over, which seemed to be fairly common in that business there.

So it did change the numbers, but it didn't sound like they were overwhelmed and the feel of the clinic walking through in the mid-afternoon didn't feel like it was real busy there. So I mean, it's part of the overall challenge and we're talking about VA because we're here, not to pick on them, but part of the healthcare sector here in Alaska and access and challenges we have, because you guys work pretty long hours there. You have, how many, it was nine when I visited? You have more, now, providers, there all together?

COMMISSIONER URATA: Yeah (affirmative), that's about right.

CHAIR HURLBURT: And you all work pretty hard.

COMMISSIONER URATA: It's all fun.

CHAIR HURLBURT: It is. It is, you know, if you were born again, you'd do it again, but you still work hard, so yeah (affirmative).

COMMISSIONER URATA: Well, it's (indiscernible - too far from microphone).

CHAIR HURLBURT: Other comments? Yes.

COMMISSIONER STINSON: The other thing that -- they kept mentioning it, and it kind of became obvious when you were walking around, while they have a lot of services, they have, obviously, enthusiastic people and seemingly really dedicated people providing those services, they were one-deep in both the hospital and the VA, and the difficulty with that is without the redundancy, an illness, a family emergency, a deployment, and all of a sudden, you could have a critical service not available for an extended period of time and that would be a concern, but I'm not sure that's our concern, but I'm sure the Colonel would, and Susan, think about that all the time.

MR. PUCKETT: Without getting redundant and reiterating some of the things that have already been said, I did have a thought yesterday with a couple of comments made by some of the folks that were talking to us about their particular unit. I'm sure all of us have heard of necessity is the mother of

invention and we could just say, "Well, necessity is the mother of innovation," because it was clear that they've done a lot of innovation.

The other point that I got yesterday was the passion that some of the individuals talking to us, that they have toward their work, I guess I shouldn't have been surprised, working in government myself, but I was surprised coming to a government medical facility and seeing the passion that some of these folks displayed.

They're very clearly engaged in their work and I also noticed that some of their staff that were kind of standing off to the side, they were passionate, too. You could just see it in their facial expressions, while they were hearing their boss explain their unit, and so that was very refreshing for me. It was encouraging for me and frankly, I was kind of pumped when we left that last explanation, you know, about the traumatic brain team and so it was encouraging and that's a couple of things that I got from the sessions yesterday.

CHAIR HURLBURT: It was like the individual employee was reacting to the bad press that the VA has received. Each one saying, "This is not what we are. This is not what we do," and you know, in a very sincere way, they basically said, "It's not fair to put a rap on -- a bum rap on the VA like this, because we take a lot of pride and really try to do a good job," and it was kind of nice to see.

MS. ERICKSON: Well, and I didn't see the paper today, I didn't know if you all noticed, but we actually had a reporter in the room during Colonel Bisnett's and Susan's presentations yesterday afternoon and I found out not long before, and was able to give Susan a head's up, but -- and she was interviewed by her afterward. So there might be something in the press today. I'm not sure and hopefully, the reporter had -- while she wasn't on that tour and didn't have the experience with the staff, was impressed with the presentations.

CHAIR HURLBURT: It was the Anchorage dispatch news (indiscernible - too far from microphone).....

UNIDENTIFIED SPEAKER: (Indiscernible - too far from microphone).

MS. ERICKSON: Any other thoughts about either of the two major presentations or any of our earlier conversation in the morning from yesterday?

COMMISSIONER STINSON: I'd never seen such a definitive link established between availability of water and sanitation clearly with clinical epidemiologic problems.

MS. ERICKSON: Any other final thoughts before we wrap up and transition to our behavioral health presentation? You have to think of one or two more things to say while Ward reads the newspaper. It could be that if she's going to write something, it will be for a longer piece, if it's not right there.

CHAIR HURLBURT: Yeah (affirmative), I don't see anything.

MS. ERICKSON: We'll keep an eye out over the next week.

COMMISSIONER STINSON: The Sunday edition.

MS. ERICKSON: There you go, a big profile piece. Well, I think we're ready to transition, then, to the next item on our agenda, which is our behavioral health presentation and Al, we'll give -- let you make an executive decision for your group.

We typically have our presenters come sit at the head of the table, so the Commission members don't have to play ping-pong and look at you all and then look at the slides and look at you all and look at the slides. So we would have you come sit up here, but then you won't be able to see the slides and we can either operate the slides for you -- do you have a preference?

MR. WALL: We can come up there. I have a slide pack printed out for us.

MS. ERICKSON: Okay, very good.

MR. WALL: I'll just have, Doctor, leave the newspaper up there, that.....

UNIDENTIFIED SPEAKER: (Indiscernible - too far from microphone).

MR. WALL: All right, good morning. I very much appreciate the invite to be here. This is a very critical

piece of our healthcare system and I'm going to take just a second to introduce the subject and ourselves. I'm going to let each of the team up here introduce themselves.

I do want to point out that behavioral health really is one of those areas of healthcare that touches and affects every other aspect of healthcare. It's always amazed me that when we have discussions about healthcare across the continuum of care, issues of behavioral health always float to the top of conversation.

I was at the Alaska Native Health Board meeting this week. I was blessed to be invited there. There was a lot of wisdom in that room and a lot of concern about different matters. As they talked about healthcare matters, the pattern came back, and that is the issues that were discussed were matters of substance abuse, homelessness, mental health, and the critical nature that plays in our healthcare system.

So that's what our presentation is on this morning and I'm going to introduce myself and then turn it over to the members of the team. My name is Albert Wall. I'm the Director of Behavioral Health for the State of Alaska. Just quickly, not to talk about myself, but to know that I'm not just falling off the turnip truck, I have been in behavioral health for about 25 years now. I'm a clinician, have been both an LPC and a licensed marriage and family therapist at various times in my career and have spent the better part of

my career working and running programs for Behavioral Health and Social Services both on the programmatic side and on the finance side and I have been the Director of Behavioral Health for about 60 days, since May. So I'm going to turn it over to the rest of the team for them to introduce themselves.

MS. BURKHART: My name is Kate Burkhart. I am the Executive Director of the State Planning Council on Behavioral Health. That is the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, and the statewide Suicide Prevention Council.

I have been the Director of those organizations for seven years. Prior to that, I had a brief stint as an assistant ombudsman investigating all kinds of complaints, often dealing with issues related to access to healthcare and then almost 10 years as a public interest lawyer with Alaska Legal Services and a legal services provider down south, again working with folks who experience behavioral health disorders in a variety of legal contexts.

MS. OWENS: Hi, good morning. Thank you for having us. My name is Xiomara Owens and I work for the Alaska Native Tribal Health Consortium and I'm -- while I work there, I primarily work with the Behavioral Health Aide Program, but I'm here kind of representing the larger department that I work with and I often site on the Tribal Behavioral Health Director's group and so a lot of my comments might kind of be

reflective of the issues that are brought up in that group.

A little bit of background on myself, too, I've been working with ANTHC for five years. I am an Alaskan. Military brought my family up here and we've stayed and I just generally have a passion for behavioral health. I am also a clinician. I've gotten my Master's from UAA and I'm in the Ph.D. Program there, too. My primary focus areas are in workforce development and training, in particular of the behavioral health workforce.

I also have a passion for the Alaska Native people and rural Alaska, and so as a part of my training, I developed and implemented a pre-doctoral internship in rural Alaska out in Bethel because I thought it was really important to have a lot of my training be in that setting, because I know it's challenging to work out there and I wanted to understand it a little bit better so I can continue to promote for those communities and for those needs, so a little bit about myself. Thanks for having me.

MR. CHARD: And my name's Tom Chard. I'm the Executive Director for the Alaska Behavioral Health Association. This is a private non-profit that represents the providers. We've got about 53, 54 members, which make up the overwhelming majority of the behavioral health providers in the state. These are your mental health treatment centers and your drug and alcohol treatment centers all over the state, from small

clinics out in the middle of rural Alaska, up to the largest mental health center, drug and alcohol center, both in the Alaska Native tribal health, behavioral health world and also in the non-tribal health.

So most of the comments that I'm bringing today are from the behavioral health providers directly. I've consulted with a lot of them to hopefully bring you guys the information that you need today.

MR. WALL: The slide that you have up here is a picture of the delta and it is representing the complexity that behavioral health is in the healthcare system. Traditionally, there's been kind of two sides to the issue. One being substance abuse and the other being mental health. The two have a lot of crossover, coexisting issues, but this slide represents that there is a braid, if you will, a rope with many strands that has to work together for the system to work.

The continuum of care is represented by, you know, community behavioral health centers, federally qualified health centers, both public and private hospitals, the Tribal Health System, of course, veterans and military health systems, the Department of Corrections, and of course, private care providers, as well.

Our responsibility in the Division of Behavioral Health is to help promote and sustain a continuum of care from one end of the spectrum to another, and if you can think of it in

that terms, that's kind of how we'll be presenting it this morning.

There is on one end of the continuum of care, kind of the less invasive lower end effort of -- I wouldn't say effort, lower end intensive service for mental health, which includes things just like counseling, getting people through troubled spots in their lives. As a marriage and family therapist, I would think of things on those ends as relational issues that you work with people and try to help them get better in that area.

On the far end of the spectrum, you have, of course, very serious mental illness and acute care that would be representative of something like the Alaska Psychiatric Institute where someone is institutionalized because of the level of the serious mental illness that they have and the care that they need.

MS. BURKHART: We see that same spectrum, continuum of care with substance abuse, where you have the folks that benefit from a screening and brief intervention when they go for their annual physical to the need for medically monitored detox and then intensive residential and intensive outpatient -- so there are levels of care with our substance abuse services, as well.

In some communities, we have organizations that can provide both and in some communities, we have organizations

that provide one and then, of course, in some communities, we have none. So that continuum of care, that wide spectrum of services is what we're going to be talking about today.

We are not going to address the Department of Corrections' services, the veteran and military system or the private sector. That's just too much, and most of the presentation today will be about adult services. The services we provide to early -- to small children, as well as adolescents, are extremely complex and diverse and we would have had to have the afternoon to include that. So today is about adults in the publically financed system. Do you guys have anything you want to add to that before we move on?

MS. OWENS: The only thing I was going to add is I think that sometimes when people think about a continuum of care, they consider it in this kind of like straight line where it's very clear and it's from one step to the next, but I think that image of the YK Delta, that braided river system, is actually pretty representative of how the services are provided and in particular, I think that Alaska, just in general, has a very complex, but -- and unique system, but it serves the needs of Alaska and so we have kind of braided our services throughout, so that people, although, it isn't necessarily straight across, they have access to things. We just kind of have to be creative sometimes, but I think we'll speak to some of that today, too.

MR. CHARD: And my take on the braided river system, so the providers, the state, the behavioral health system is beholden to its funders, like anything else, and we've got a lot of funders out there that all would like to know a certain piece of what's happening. So whether it's IHS, the feds, the state, Medicaid, Medicare, what we're going to talk about in today's presentation touches on a lot of that, but to me, that braided river system represents as much of the complexity of the levels of care, as it does the complexity of the funding streams that ultimately deliver the care in communities across the state and whenever that care is delivered through such a complex system, you can imagine the reporting requirements and the hoops that you have to jump through are also a bit complex. We'll talk about that later.

MR. WALL: So on this slide, we're addressing just the state behavioral health services and how that works with the Division of Behavioral Health. We are basically divided into three parts in the Division. There are prevention and early intervention that deals specifically with attempting to prevent long-term issues with mental health and behavioral health.

There are treatment and recovery grants that go out to providers that provide services, of course, across the spectrum and then we do provide some direct service at the more intensive levels at, of course, Alaska Psychiatric

Institute, and we also provide direct services through a program at Therapeutic Courts called the Alcohol Safety Action Program, ASAP program.

MS. BURKHART: So examples of some of these services are pictured in the slide. Our prevention system is based on the strategic prevention framework, which is a national model that allows communities to drive their prevention efforts based on their needs. So our prevention system is not Al and Kate telling communities they need to prevent X. It is communities going through an assessment process to determine if our most pressing need is suicide or depression or substance abuse or teen pregnancy, whatever it is, and then using that. That guides their choice of evidence-based prevention practices and we see a lot more success using that framework. So that's that groovy flower.

There's also a picture of the detox center in Fairbanks. That's a medically monitored detox center in Fairbanks with 16 beds. Two of those are for folks who are addicted to opiates. That center is at capacity most of the time and there's also a picture of Polaris House, which is a consumer-driven clubhouse in Juneau that provides support, life-skills support, housing support, employment support, moral support, emotional support, to folks with serious mental illness. It's a peer-support consumer-driven program and that, too, is funded in part by the Division of Behavioral Health, and so you see that wide

spectrum of prevention, treatment, and recovery services in what we do.

Xio can share some of the culturally relevant and -- programs that are based in traditional practice and I think that's one of the areas where Alaska is -- has great assets, is the fact that our indigenous culture has lead to these behavioral health programs that really resonate with our population.

MR. CHARD: Just that -- I know one of the points of confusion when you start talking about behavioral health in the state of Alaska is that as a state, we've chosen to provide grant funding and basically contract funding to private nonprofit corporations that deliver the services. So this is different than in a lot of the states down south where it's county health providing that service or it's the state directly providing that service.

With the exception of API, which is a major exception, most of the funding the comes through the Department, through the Division of Behavioral Health, is actually awarded in grants, which I characterize more as contracts, with private corporations that agree to deliver the services per the Department and Division standards and provide the care that we all need.

So I think that there's some confusion out there because the, you know, folks in communities, particularly, will see

Anchorage Community Mental Health or Fairbanks Community Mental Health and they'll assume that is a state-run facility or that those are state employees or that somehow the state is involved. The state is involved in that it provides grant funding to deliver the services that those private corporations agree to deliver.

MS. OWENS: And so on the tribal side of things, in the couple of years that I have been working at ANTHC, it's been exciting to hear about our different partners and their ability to develop services in a way that meet the needs of their specific communities and their cultures.

For many years, you know, the typical model of the services that are provided in urban settings don't necessarily translate into working in a village. In particular, when we talk about the stigma of behavioral health in general and people trying to even reach out to get assistance, it's much easier to do that when you are going to a service that is aligned with yourself as an individual, traditionally and culturally, and so many of the programs -- it's exciting to see how the different regions have been able to meet their own needs while also meeting the structural -- and needs of the different funding sources, like what Tom was talking about earlier, and so I don't know how much more you want to know about that, but I think just generally speaking, the ability to meet the broader, structural needs, in a way that is

aligned with cultural and traditional ways of being, we see many more results in that way.

MR. WALL: I'm going to stray from the script for just a second, if I don't get in trouble, as well. So this discussion we just had on this point brings something up for me and that is the difficulty, sometimes, that we have in the service field of mental health and behavioral health of explaining the complexity of what happens in the state and what mental health treatment is and does.

Because we primarily use nonprofits to provide the services, they, of course, are providing the direct services. So when we look at the effects or the outcomes of what services are being provided with the dollars that we provide, it is sometimes difficult to translate that into, this is a good service and has this amount of impact in this area and this is not. It's difficult to take that across in numbers and data because we're not providing the services. I don't have a clinician that's out there doing the counseling. I'm doing this through other agencies.

The other piece I would like to point out that -- is that a lot of times when I'm speaking with people, especially in the medical field, there is a very, almost rigid understanding of the medical model of how treatment occurs and there -- in your mind, it may be easy to identify an illness or an injury in how that's treated and what the outcome of that should be.

For instance, if someone breaks their leg and they go to the ER and they get a cast on their leg, well, in a certain amount of time, they should be better and then they go home and everything's fixed. Mental health and behavioral health services, of course, are not like that. They are long-term, many of them chronic, and while people do improve and get better in services, a lot of times, it's a lifetime struggle with them and so reporting the outcomes and impact of the services that we provide needs to be done in that context. That was my little bunny trail. I apologize.

MS. BURKHART: Well, that's good, though, because it leads me down mine. So the recovery process from a mental illness or a substance abuse disorder is dynamic. It isn't Point A to Point B, cured. It is Point A to Point B, better, to Point C, even better, to relapse, to try it again.

It's much more -- a lot of times we characterize it like chronic disease management with diabetes. In my mind, it's much more like cancer. You have cancer. You have a very intensive treatment period that's really kind of awful and you get better. You're in remission and then three years later, 10 years later, it comes back, and so it's that kind of recovery process and that's where quantifying the impact is so difficult, is because the get-better happens over and over and over again at different levels of functioning and emotional health.

So that's one of the things to keep in mind as we move through this presentation, is that our service providers function in an environment, it's almost like maybe a dermatologist, where -- like it's a chronic skin condition and you just keep coming back, rather than a broken leg.

So Deb said that we should include some prevalence information. The National Survey on Drug Use and Health is used by the Substance Abuse and Mental Health Services Administration. It's administered every year and it's been used for years and years. It's been evaluated and it's the standard most states use for determining prevalence and Alaska started using this as our prevalent standard about two-and-a-half, three years ago.

So according to the National Survey on Drug Use and Health, 8.25% of Alaskan adults, again, we're only talking about adults today, this is people over age 18, are estimated to be dependent upon or abusing alcohol in the past year, 2.39% of Alaska adults are estimated to be dependent upon or using illicit drugs in the past year and that's inclusive of marijuana, 4.12% of Alaskan adults are estimated to have a serious mental illness in the past year, and almost 20% of Alaskan adults are estimated to have any mental illness in the past year, and so with those last two variables, the 4%, those are going to be the folks with the chronic mental illnesses, things like schizophrenia, personality disorders, clinical

depression that might lead to a suicide attempt.

The 20% are more the folks like Al was talking about, the relational situations, mild to moderate conditions, so -- and we also have estimates on use of drugs and alcohol. Almost 14% of Alaskans surveyed had used illicit drugs in the month prior to being asked, a little over 5% had misused pain medication contrary to or without medical direction and over 25% of Alaskan adults surveyed had engaged in binge drinking, which is five or more drinks in one setting, at least once a month, if you're a man, and four or more drinks in one sitting, not setting, sitting, at least once a month in the past month. So yes, sir.

CHAIR HURLBURT: I wonder, and this interrupts you a little bit, but kind of looking through your -- I think we're getting into some of the clinical kinds of issues, which we really want to hear, but if we could go back to a comment that Tom made and I might be interested, particularly Tom and Kate, in your response to this, the dominant focus for the Health Care Commission is related to cost of healthcare overall, including behavioral health, because of our unsustainable level of costs now, irregardless of the need that's out there and the Legislature, of course, has it right in the face of it now with the throughput going down and so on, and so you mentioned that our model here, are largely grants to nonprofits for behavioral health services that governmental

entities operate in some other places and one of the things that I've been hearing for the past year from some of the members of the Legislature, for example, are concerns regarding outputs and accountability, not specifically picking on behavioral health, but in general, for how we operate here, but with a perception that maybe contracts are a better financial mechanism to use, rather than a grant to assure accountability.

I've heard other people say, "Well, you can develop either a grant or a contract to have accountability," but in terms of the agencies that are part of your constituency or Kate, with your broad involvement, do you have any sense on that? Is there an advantage in terms of accountability and in terms of outcomes and having happen what we want to have happen, like using one financial mechanism or another, and again, I apologize, Kate, because it gets you off track.

MS. BURKHART: It's good.

CHAIR HURLBURT: And then we're getting into, I think, we're all very interested in what you're saying.

MR. CHARD: So Dr. Hurlburt -- Dr. Urata, you have a question?

COMMISSIONER URATA: I have a related question and when I heard about the grants, I was wondering, well, what, you know, what are the outcomes and since he mentioned it, I thought, you know, emphasize the need, for me, to know how are your

outcomes and I'd like, for example, how long have you been doing this? Has it been two or three years and do you have outcome data? You know, I look on your Alaska scorecard. Is your suicide rate going down? Is the alcohol-induced deaths going down? Child abuse and neglect, is that going down, and are we getting closer to the national average in some of those outcome measures, because I think those are good -- the Alaska scorecard is a good way of looking at it.

MR. CHARD: So.....

COMMISSIONER URATA: You know, is this -- is this way of doing things working? Thank you.

MR. CHARD: So I think I can address both of these questions. To Dr. Urata's point, the scorecard is more of a population-based indicator. So the Department, and to a large degree, the providers have engaged in results-based accountability, results-based budgeting and performance-based budgeting.

The scorecard represents the population level, the population indicators, which, of course, involve many players far beyond the provider, far beyond the Division of Behavioral Health, far beyond even the mental health and drug and alcohol system in general, I mean, corrections, private players, all of those. So the population indicators are an important way to measure our progress as a state and our collaborative effort.

The -- if you drill down to the Division level and the provider level, that's where performance-based funding measures come into play, which, Dr. Hurlburt, addresses more of your question. Since 2006, I believe, the State Legislature passed a performance-based funding mandate for the Division to track the performance of its grantees. So every quarter, the grantees provide data.

They actually provide data on an ongoing basis, but every quarter, they provide data to the Division of Behavioral Health and that data includes the performance-based funding measures, upon which they're measured at the end of the year and that your funding is contingent on how well you did in your performance.

So we measure things like, how long did it take for somebody from the screening tool to the first service? Were their quality of life indicators any better? Was their health and better, and we will get into a little bit more of this, but that's measured every 90 to 135 days with a client status review. It's measured at intake. It's measured at discharge.

The problem is, from kind of a little bit of a margin here, that we look at the episode of care or the treatment from the time you walked into the door to the time you walked out of the door and we are constantly being asked, "Well, was this -- was anybody better off, like five years down, 10 years down," and frankly, our system isn't really designed to

measure that.

Our system was set up to design -- like you walked in the door. This is what your health quality of life indicators looked like. We improved them per our agreement. You walked out of the door in a more healthy, wellness state, and you know, good luck. We might see that person again in our system. We know that we probably will, but we, you know, have built-in recovery supports and have built in some things into our system that help. I do -- I can't remember if we gave you guys the client status review (indiscernible - speaking simultaneously).....

MS. BURKHART: It's in the background binder and we're going to provide all those materials with links to Deb and her staff so that you'll have access to them. So it's the binder, the client status review.

MR. CHARD: And Dr. Hurlburt, one more point to a question.....

(Intercom Noise)

MR. CHARD: Yeah (affirmative), I thought it was somebody on the phone, too. You had asked the question about grants versus contracts. We had provided, actually, the Legislature, at this last session, some information on this because it's our opinion, that you know, there's pros and cons to both systems, to the grant system and to the contract system.

Grants are more flexible. They allow the Division of

Behavioral Health and the Department to work with the provider to develop certain systems, certain initiatives, certain things. So in those contexts, it may be that grants are better.

In the kind of standard delivery of care, people come in, we do A, B, and C, people walk out, it may be the contracts might be a better way to hold people more accountable and actually be a little bit more clearcut in the deliverables. So I think the answer to that question is, probably we need a little bit of both, but I -- maybe with a mind that grants would offer the endcaps or initiative services and things and as we move into kind of standards of care, it would move to a contract. Al is really the person that should be answering this question. He's both the expert in budget and DBH.

MR. WALL: No, I mean, I appreciate the perspective of the providers in that issue as well. It doesn't necessarily have to be an either/or. There are different ways to get at that issue. You can do grants that are fee for service, that are, you know, based on a claim and track things like that, like you would any other system. So there's different ways to get at that.

The way the system has been designed, historically, is to provide funding for the nonprofits where their other funding mechanisms have -- aren't sufficient enough to provide the services. So our area of focus are unresourced people, the

patients that have absolutely no capacity to pay. In some cases, they don't even have Medicaid or any other source of payment at all and so that's what the grant funding is there for, is to provide services to those -- to that particular group of people, and I think I'm just going to leave it done.

MS. BURKHART: I think the gentlemen covered it. We can provide the slide deck that we provided to House Finance on this issue to you Commissioners that lay out the different pros and cons of each mechanism. We did not provide a definitive answer. We just tried to illuminate if you're -- how to make the decision.

MR. WALL: I'm sorry, and if I may, just on this, toward the end of the presentation, there is a couple of recommendations that we have and things that we're working on to fix things. One of those issues is what I'm calling grant reformation. So we are currently in the Division going through a process of redefining how we do our grant programs and making sure that we are getting out of the grant program what's necessary, what's efficient for both the providers and for the patients and for the Division administratively, and then also, we'll be able to provide data to the Legislature and other groups as well. So we're going through that process and looking at different ways of addressing the issues that surround grants.

REPRESENTATIVE KELLER: A question on point here, I

realize we're unique up here and that we primarily offer these services through grants and all that, but surely, there are comparisons, aren't there, with other states on the short-term and the episodic level so that, I mean, we're not completely pioneering this. I mean, it occurred to me as you were talking, how much responsibility falls on you all, you know, in coming up with an evaluation process that is believable and what I'm asking is, do we -- has any effort been spent looking at the valuation of other states?

MS. BURKHART: So we have looked at how other states have addressed changes in their payment structure. Some states either bundle their services and then pay for it in a bundled way with certain health outcomes required to get the payment. We have looked at states that have done it that way. We've looked at states that have done capitated rates. We've looked at states that have done regionalization, so catchment area kinds of things, which behavioral health used to use like maybe 10 or 15 years ago. So we've looked at all of that.

In addition to the grant reformation effort, we're also going to talk about the issue around behavioral health Medicaid rates and the methodology for setting those. One of the issues providers face is that they have all of these funding streams and very few of them are actually adequate by themselves and so they all have to be pulled together in order to provide the service and if one of them gets hinky or falls

off, then it affects all of the services because none of the funding streams are adequate to provide everything and so if we look at the next slide, this lays out how the funding in the public continuum of behavioral health is laid out by level of care and so this is Al's system slide.

MR. WALL: This slide's actually from 2012, the FY 2012, and it's the slide that -- I actually really like this slide because it shows the continuum of care all in one shot. It has the different types of services that we discussed and the cost associated with those services across the continuum of care.

On the far left, you have, you know, the lower expenditure types of services, which we provide, which may be something like prevention, early intervention, in which you're basically messaging the public about certain health hazards and so, you don't want to drink too much. You want to drink responsibly. You don't want to drink while you're pregnant, the dangers of tobacco use, and so on and so forth. So the prevention services are on the far left.

Then on the far right, you have, of course, long-term care in a facility. That is the highest level of cost for behavioral health. So if you look through the continuum of care, you also see that the line in the white bubbles, I'll call it, shows you where the funding sources come from and so this represents that -- those many different tributaries in

the river that help float the grantees or provide the funding for the services that they need to give to their clients, that one source of funding doesn't alone provide. I'm not sure I'm going to go into each one of these, because I think you can read for yourselves there.

MS. ERICKSON: Could I ask one question related to the funding, unless you're going to get to it a little bit later?

MR. WALL: Yes.

MS. ERICKSON: Where you've noted GF as the funding source, state general fund, is that all funds that have come from the Mental Health Trust?

MS. BURKHART: Absolutely not. General fund is general fund dollars. If it comes from the Alaska Mental Health Trust Authority, those funds are designated as Mental Health Trust Authority authorized receipts, MHTAAR, and so the proportion of MHTAAR dollars to GF and federal is minuscule. If you see what we spend in federal funds, whether from Medicaid or from the block grants, the Mental Health and Substance Abuse Prevention and Treatment Block Grants, and general funds, you see hundreds of millions of dollars.

The annual payout from the Alaska Mental Health Trust Authority, which is from the income on the corpus, is between 23 and 24 million. About eight of that is for their admin costs. So that leaves about 16 million, that's for both their office and the Trust land office. So then -- and that also

includes continuing projects like they staff -- they have a staff -- they fund a staff person in my office and so that leaves about 16 million for programs, initiatives, services and focus areas, and so that's spread across four, really five beneficiary groups; folks with developmental disabilities, folks with serious mental illness, folks with chronic alcoholism and other substance use disorders, seniors with alzheimer's disease and related dementia, and then brain injury, and so that 16 million gets spread through the focus areas to all kinds of things, therapeutic courts, workforce development, housing, and so if you look at that, for folks with behavioral health disorders, if it were equitably distributed, they would only receive about eight million of that 16 million, compare that to the hundreds of millions of dollars in GF and Medicaid.

That's where the lion's share of the work is happening, is through the federal dollars we receive from Medicaid, the federal dollars we receive from the Indian Health Service, and then the general fund that the Legislature appropriates, so that's.....

MR. WALL: Yeah (affirmative), and I think that's a good perspective check for that particular issue. It's not to say at all that the Trust is not a tremendous asset and benefactor or services and mental health in the state. They are a tremendous advocate and in particular, they allow us to

develop new services in areas where services are not currently being offered and that's where their strength is.

When there's a gap in the continuum of care, there's a small segment of the population who are not being served in their needs, simply because of whatever hasn't been developed. The Trust is really good at coming to meet that need, but I think what Kate points out is that it's a matter of perspective.

There is, in some cases, a misconception that they fund all mental health services and they certainly don't. So we just want to point that out. They're a very necessary, tremendous asset to us. They do a great job, but they don't fund all of our services, absolutely.

I also wanted to go back and point out something. I've been kind of picking up through this conversation that -- I want to alleviate the misconception that we don't have data. We do. We certainly have a scorecard like the one you have, for each of our grantees, and there is that information that we track and keep out there. So sometimes the questions that we ask of the data, we can't get to, or the answers that it gives us, don't mean a whole lot, and I'll go back to the marriage and family therapy issue again.

If you ask any marriage and family therapist what his success rate is over time, he'll probably blush, because the success rate of something like marriage and family therapy is

usually, generally fairly low. I've been doing it a long time. The issue is it's a matter of relationship between two people and they have choices, you know, so when you're dealing with things of that nature, it's a matter of choice between two people.

So on the more clinical end, we have some better information of data because it's there, but when things come down to individual matters of choice, then it's hard to track outcomes in that, of course. So I just wanted to point that out, as well.

MR. CHARD: The issue, and this is Tom Chard again. The issue that, I think, our system faces and our providers certainly face, is that as soon as you come up with a client status review that asked what, you know, collectively we all want to ask today, tomorrow, somebody else is going to ask a different question and all of a sudden, our system is out of date. We're not asking that question.

So when, you know, we scramble to try to get the answer to the question of the day, it's difficult sometimes, because we're really turning our system sideways, upside down, you know, diagonally, to try to shake out an answer, that you know, we just didn't think of earlier, and I know this is in your packet, I've got an extra copy of a client status review and the Alaska screening tool, that you know, if you want to shift that around, and then also, Dr. Hurlburt, as it would

happen, I have the grants and contracts presentation material that we developed for the Legislature.

MS. BURKHART: He's a Boy Scout.

MR. CHARD: I was a Boy Scout, and so.....

MR. WALL: I also want to point out, while we're still on this slide, that we are constantly in the state of attempting to shift services from the right-hand of the spectrum to the left. So we're developing ways in which we can move people from a higher cost center to a lower cost center. It's a tremendous area of interest in effort for us to do that.

If you look at the cost centers, for instance, I'll just use -- I'll pick on myself here, so API, where's it at, acute psych at API, basically it comes to about 17,756 average cost per client, for an individual there. So that's a particular level of care and it's necessary.

So our desire, of course, is to develop a little lower costing types of service that can meet some of those needs and move people toward the left on the chart, so that they, you know, that the cost is less and the level of care is appropriate. So Doctor, did you have a question?

COMMISSIONER STINSON: Is that along the lines of a 72-hour hold for somebody who is in danger of harming themselves or others?

MR. WALL: That's an average 10-day stay.

MR. CHARD: Yes, in other words, that's why they would be

API, is because.....

MR. WALL: Yes.

MR. CHARD: .....they're a harm to themselves or others.

CHAIR HURLBURT: Al, let me ask you a question that's not totally fair and probably unanswerable, but again, because of the financial realities that we deal with, your comment was totally reasonable, totally understandable, is if you're dealing with marriage and family therapy and counseling, but your success rate, in a society where we have a 50% divorce rate, that you're dealing with two people and you help them and try to facilitate a relationship, but they make their own choices.

Now, to give an example, in the last job that I had, we had a disease management program, and a lot of people were very enthusiastic about that and theoretically, you can do a lot of good and reduce a lot of morbidity, mortality rates and so on, but the measurements were widgets, were contacts.

MR. WALL: Yes.

CHAIR HURLBURT: And we had nurses and we had health educators in that program and in pushing for outcomes, saying, "I really want to see in our diabetic patients, the hemoglobin A1C's coming down to acceptable levels and improving that and they pushed back and said, "Well, Ward, you know, we -- people have to make their own decisions. We can talk to them. We can try to educate them. We can influence them." The end

result was that I took about half of that staff and put it in complex case management where we really could improve quality of care and improve outcomes and significantly reduce costs.

So at least for me, what you're talking about would be much tougher to deal with and I understand that, but where we're interested in outcomes, what you say is totally reasonable and it may be an unanswerable question, but how do you deal with that? You know, you're right, you say, "We're dealing with people. They make their own decisions," but where the resources are limited and where you're interested in outcomes, how do you deal with a question like that?

MR. WALL: So that's a great question and that's really the conundrum that we face on a constant basis and have for years, as behavioral health has come to the forefront of issues. So I was speaking specifically of data issues when I was talking about marriage and family therapy, but let's take even a more acute specific issue along the matter of choice and things of that nature.

So often times, individuals with serious mental illness are stabilized and can be quite stable and productive in society, live independently and so on and so forth, hold down a job, as long as they go through the paces of their medication management.

That is a choice. So if they take their medicine on a daily basis, they are stable and they do okay. If they choose

to go off their meds, that is a personal choice and that leads to decomp and they, you know, end up back up in a serious situation again.

So again, how do you -- that's a great question. I'm not answering your question. I'm saying it's probably a little worse than just the choice issue. How do you, not only track that when it comes to a patient who's been in the continuum of care for a long time?

You know, we talk about the issue of recidivism and tracking that in data, but what happens with that patient that you're dealing with that's been okay, stable for three years and then goes off their meds and gets back in the system again? Are you -- where do you count them in the data, so-to-speak? That's a difficulty.

MR. CHARD: And Dr. Hurlburt, a little bit later in the presentation, we've got a couple of kind of case examples that might illustrate that point and touch on the funding streams and touch on some of those personal choices and access to services and services that are available to those individuals. I think that will help illuminate that discussion.

I do, because it's a term of art that we use, and when we're talking about our either substance abuse or mental health system, I think it's important to recognize mild, moderate, and serious disorders. On the, you know, drug and alcohol side, it's, I use. I abuse. I'm dependent. I have a

serious substance use disorder.

On the mental health side, it's, I have a mild to moderate problem, and then all of a sudden, it's starting to escalate, either in a kid system, where it's a serious emotional disturbance or in the adult system, where it's a serious mental illness, also known as serious persistent mental illness, on a federal level.

In both of those cases, our system has actually shrunk to only really be able to care for people with serious disorders. So you're not going into the community behavioral health center because you're feeling sad. You're going into the community behavioral health center and we're able to serve you because you have a serious mental health problem.

It's kind of akin to, we don't see people with colds. We see people with like, you know, heart attacks, basically, and so I want to make that point because, you know, I think it's easy to think about the person that might have a little problem with substance abuse, which is a serious problem, or the person that has a problem with mental illness, attachment disorders, things that maybe don't rise to the serious disorder level and those terms of art that we use, I think, you know, we understand them when we're saying them and prevalence data and in funding terms, but I think it's important to communicate that, as well, and those case examples that we have later, I think will help touch on that,

as well.

MR. WALL: And one other thing, if I could point out real quick, just on the cost issue, I said we're trying -- we attempt to push people to the left where they cost less and their needs get met at an appropriate level of care, that often causes a balloon in cost in other areas.

So if they move out of a grant-funded area into a Medicaid-funded area, yes, we get the 50% or enhanced maturate for that service, but it still costs us our general fund expenditure in that particular Medicaid are to grow by whatever our match is. So it's not -- we can't alleviate the financial issue. It's going to be there. It's going to come out of some pot of money somewhere. It's just incumbent upon us to make it cost as least as possible with the appropriate level of care for the individual's needs.

MS. BURKHART: So if you go to the next slide, we have some data on Medicaid claims, beneficiaries, and payments over the last -- up until 2012, and one thing to mention, I'm hopeful that you have heard about the Department's effort to -- it's the super utilizer case management.

So you've heard about that. A large number of those beneficiaries, Medicaid recipients, actually are our folks and are benefitting from the enhanced case management and I think it's also important to note that a lot of our providers are able to track comorbid conditions. They're measuring things

like blood pressure, A1C levels, all of that, either because they're part of a vertically integrated organization, like a tribal health organization or because they have a nurse or a PA on staff or a relationship with a primary care provider. So those are also ways to, not only help mitigate comorbid conditions, but also to help monitor side effects from medication, which are substantial.

So we won't go through, line-by-line, this chart, but it does show you over time what behavioral health Medicaid services have -- they -- we have enrolled more recipients. The cost of beneficiary has increased, due in part to the fact that we focus, almost exclusively, on the most acutely mentally ill or addicted and you can see the percent change in claim payments and cost for beneficiary.

MR. WALL: One of the struggles we then have is we have discussed this in our conversation already, but the system is designed to care for the most acute levels. So in mental health and behavioral health, there's this kind of vast middle gray area where someone is struggling with an issue, but they haven't gotten to an acute level yet where it's, you know, critical, but the services, in some cases, are not there for the middle gray area, so because they are going unserved, then they get increasingly worse and they end up in the acute.

So our efforts are to, you know, create a more robust continuum of care in that vast middle gray area to alleviate

the higher cost centers and to care for people properly. I just wanted to point that out, as well.

MS. OWENS: I just wanted to add something to that. So when we talk about behavioral health services in the Tribal Health System and the availability of services, often times, and in many -- so our system, we've got village-based services. There are services then at possibly a regional hub and then in the -- so in the village, a hub, the region itself, and then, you know, as it goes up the continuum of care, they might need to come to Anchorage to go to ANMC or API, but as we talk about the attempts to really put some more efforts up front, so in the prevention, early intervention stage, where many of our villages don't have any behavioral health providers at any level, one way that we try to address that is by our behavioral health aide workforce and that workforce, in particular, they all operate under, at least Master's level clinical supervision, but a lot of their efforts are primarily focused in prevention and early intervention and so when we talk about Medicaid services, too, one of the current efforts is a state plan amendment that will increase the number of codes that can be billed to, specifically for services provided by behavioral health aides, and so I think, that you know, and I'll talk a little bit more about the behavioral health aide program a little bit later, but when you talk about behavioral health services in a

village setting, often times, the BHA's are described as the backbone of the behavioral health services for those communities and so being able to have this resource and be able to bill for those services to expand the availability and enhance access to it, that's something that we're really excited about.

MS. BURKHART: So this slide shows the general fund investment in grants. This is what's been appropriate year-to-year to provide grant-based services to folks who are unresourced for special initiatives and to help providers where their funding streams don't always cover the cost of doing services.

So the orange line, the orange column is the funding for substance abuse related grants and the golden column is for mental health related grants. The Division administers those from a single pot, the Community Behavioral Health Treatment and Recovery Grant Program.

One of the reasons we include this slide is to show, not only the investment in the system, but also the continued disparity in funds available for substance abuse services versus mental health services, which is compounded by the fact that most folks who need substance abuse treatment services are single without children and they're not disabled or they are disabled, but they haven't been found disabled by the Social Security Administration, which means they're

categorically ineligible for Medicaid and so Medicaid is providing a lot of mental health services, far fewer substance abuse treatment services, not because they're not a covered service, but because the folks that need them are categorically ineligible and so the disparity in general fund is compounded by the way Medicaid works. Next.

CHAIR HURLBURT: Is there a rationale? Just eyeballing the trend there, it looks more resources are going into mental health, as opposed to substance abuse, and are both challenges that are there, maybe both are increasing, but certainly, we hear more and more about the substance abuse issues. At the ANTHC mega meeting the other day, rolled a comment and said, you know, if you ask are there are five heroin babies now, you'd say, "No more," that he's hearing more and more, and in many places, we see that's society-wide now. Is there a reason why it's almost flat-line, maybe up a little bit for substance abuse, but maybe a 30% increase over those few years for mental health?

MS. BURKHART: Well, I can comment over the time that I have been in this role and been in front of the Legislature asking for funding on the part of folks that experience behavioral health disorders. In the spectrum of stigma, the folks with substance use disorders are at the bottom, right, they're the most stigmatized because they choose -- people believe that they choose to be addicts. That is not true.

Addiction is a chronic disease, and so it's required a lot of education for folks to understand that for a lot of folks, they have a co-occurring mental health and substance use disorder.

So they're self-medicating. They're compounding their mental health problem with their substance use disorder and we also know the impact of trauma and adverse childhood experiences on your susceptibility to becoming addicted to drugs or alcohol and so it has taken a lot of work to invest in a substance use system.

We have also seen, and it's not reflected in this slide, an increase in the investment in corrections' ability to serve folks with substance use disorders and from the Board's perspective, that's wonderful, because that's where folks -- they're a captive audience. We can provide the services there, and so there's been growth in that system, which is something that we believe helps deliver the services to the folks that need it, even though it's not in the Department of Health's budget. This is just the Department of Health's budget.

So I think that's part of it. It might also be a remnant from the way the system historically worked. For a long time, substance abuse was separate from mental health. They were two different divisions and from my longstanding Board members, I have some Board members that have been around for

25 years, there was always a disparity in resources, even when they were in separate divisions and so when the divisions came together and we had behavioral health, they brought that disparity with them and so the base budgets were the base budgets and so increments that were added to enhance services didn't necessarily rectify that disparity. So I think that's part of it.

The move to serving people in a co-occurring way, having our centers be able to serve, whether you have a mental illness, a substance use disorder or both, and the vast majority of people have both, has allowed for us to use these funds in a way to try to mitigate the disparity.

I don't know that we have effectively mitigated the disparity, but I mean, that's a way that the system has tried to deliver services so that it's more equitable.

MR. WALL: And if I may, that -- the issue of the disparity between substance abuse and mental health is not, of course, Alaska-specific. So that's a historical development in the healthcare of the nation. They really are held separately and there's been longstanding attempts to integrate that care and it's been resisted in some circles, clear up to the, you know, very highest level of NASMHPD, who is the mental health type organization, and NASADAD is the substance abuse organization and so there's, you know, there's this little conversation between them constantly.

I would like to point out that it has been some time, if you look at this particular chart, since there was an infusion of general fund to the grant line, but this last session, and then I'll point this out, I believe that the Legislature and the Governor's Office are responding absolutely to the growing need and the evidence of behavioral health needs in the community by the anti-recidivism money that came through at the end of the session. That was a specific gift, if you will, to the cause, because the need is recognized and they have responded to that need.

So I have high hopes that will continue in the future and that those dollars will have tremendous impact and I believe they will.

MS. BURKHART: So just being aware of our time, it's 9:30 and we're having so much fun that we're only on Slide 7. So we're going to try to talk faster. So this next slide is our episode of care slide and Tom and Xio are going to share how this works from an urban perspective and then -- well, let's do the rural perspective first, and then we'll do the urban perspective, and just recognizing that while this is numbered, like it's a linear discreet process, it's not. It's a messy, complicated process.

MS. OWENS: Sure, and actually, I think for sake of time and you guys can read the list there, I've just -- to depict what it looks like in a rural setting, imagine that you've got

an individual who was out in a village that doesn't have behavioral health services or a behavioral health provider directly there and they are reliant upon an itinerant, maybe BHA or a clinician coming out there every so often.

They get identified. The BHA might be able to provide the initial orientation to what kind of services are out there, do an AST and CSR with them, but then they have to connect with their clinician, whether they are in the hub or in the regional setting, to get them that higher level of care, so to do an actual, like an integrated intake, behavioral health aides can do substance abuse, kind of this, again, disconnect between substance and mental illness, they can -- they can do services related to substance abuse, but not mental illness.

So if that's identified, then they have to go up to a higher level of care provider to be able to do that and then again, if they need psychiatric care, that's a whole other level of care that they need to get connected with and if they are fortunate enough to be at an organization where they have a psychiatrist on staff, great. They can connect with them at the region. Otherwise, some of our tribal health organizations contract with psychiatrists using telehealth. Some of them are from the Lower 48. Others, they will -- they'll work with API to get those services met and often times, and I know we'll talk a little bit about telehealth

here in the future, but telehealth, telemedicine is something that within the Tribal Health System, we've been using for a very long time.

It's kind of -- it's a staple of the work that we do and the services that we provide and to the best of our ability, we try to use that before relying on travel, which isn't always reliable, if you've traveled out to the village, depending on weather and whatnot.

So as you can see, and it kind of goes back to that initial image of the braided river of services, and connecting with services can be complex, but we do our best to really connect people, depending on where the level of service is available, and again, with the intent of having people be able to be served in their own communities and be surrounded by the people and supports that can help them to remain healthy in a way that's natural to them.

MR. CHARD: And I heard the Commission's discussion earlier about necessity is the mother of invention, and man, if the Tribal Health System is not the example of that, I don't know what is.

The episode of care that -- this slide that we wanted to communicate, this is more or less what happens when somebody walks through a mental health treatment facility, a substance abuse treatment facility or a facility that is able to take care of both, a community behavioral health center.

When folks come in, they're initially -- they talk with an intake specialist or an intake team. Usually, these folks are coming to us because they're referred, the Office of Children Services, DJJ, the Division for Juvenile Justice, the courts, particularly the therapeutic courts, Department of Corrections, somebody's employer, or in some cases, family or the individual actually is walking through the door themselves.

They'll meet with the intake team. They'll do the Alaska screening tool, which we passed out earlier. The screening tool was developed here in state. It allows us to collect data that is Alaska-specific. It collects data on trauma. It collects data on brain injury, domestic violence, sexual assault, feelings of safety and security, in addition to mental health, substance abuse issues that the individual might be facing.

Assuming that the individual is somebody that would benefit from care, they're enrolled in services. They fill out that first client status review to get a benchmark data from how they're doing, how they're doing in employment, how they're doing in housing, how they're doing in healthcare, how they're doing in behavioral healthcare, to include mental health substance abuse.

They walk through and get a diagnosis. There was some discussion this past session about residential substance abuse

treatment services. In particular, the residential substance abuse treatment services are guided by something called the ASAM. So the ASAM, and we're on version three, is the American Society for Addition Medicine.

What it does, is that it helps the substance abuse counselor identify what's going on with the individual and recommend placement. It's got levels of care built into it, all the way from outpatient to intensive outpatient to residential treatment to detox, either medical or social.

So the ASAM criteria is what our substance abuse providers use by and large for placement. The mental health folks use something called the DSM. We are currently on DSM version five. This is the diagnostic and statistical manual for mental health disorders. It actually includes substance abuse disorders in there as well.

The DSM5 is a recent and major renovation to our system. The DSM4, which proceeded it, was based on an axial diagnosis system. This is not. So that has caused no degree of havoc in our systems and both of these fall under a system of classification coding called the ICD10. We are now working on the ICD11. I just found out last night, as I was reading through things preparing for today's meeting, because this is great bedtime reading, the ICD10 and the DSM, so all these things have codes.

This is like, you know, somebody's got a disorder. You

look up the disorder. You look up kind of the prevalence information, the diagnostic criteria, things, I mean, this all guides the clinically prepared counselors and clinicians in their decision-making for treatment and working with the client.

The thing is that like -- so in Alaska, particularly on the substance abuse side, so this person needs residential treatment services, but there's no residential treatment services available. What do you do, or this person needs intensive outpatient, but you know, your community doesn't have an IOP provider. What do you do?

The DSM5, one of the major revisions over the DSM4, which I think is interesting, is the DSM4 and what proceeded it, used a system where the person had to fail before they could move forward. So you failed in outpatient, so therefore, you are qualified to go to residential. The DSM5 recognizes that maybe that's not the best system and moves our system forward on that.

These ICD10 codes, this is the stuff that people are entering into the MMIS system, the Medicaid Management Information System, to hopefully get a reimbursement check, and I do underscore hopefully. The thing is that these codes are also used for private insurance. They're also used for other payer sources, as well, but I wanted to bring these and we can pass them around, if you guys want to thumb through

them or look at them. It's very riveting reading, let me tell you.

UNIDENTIFIED SPEAKER: (Indiscernible - too far from microphone).

MR. CHARD: If you're anything like me, the first thing you're going to do is look up your own disorder, try to figure out where you are on the spectrum. Yeah (affirmative), it's actually a pretty interesting read in that. Wait, are we still on -- I wanted to finish the episode of care real quick.

MS. BURKHART: Fast.

MR. CHARD: Just one more thing in the episode of care, so we're on diagnosis. We use the manuals for diagnosis. We go to the treatment plan. We develop a treatment plan with the client, because clinically and ethically, the individual has to be involved in their treatment in order for it to work. Them identifying parts of their recovery is critically important to actually achieving recovery.

We go to either clinic or rehab services. You've heard presentations from Margaret Brodie and the Medicaid folks about some of the services that we offer in state around clinic and rehab services, optional services, mandatory services, they all fall into this category.

We do that client status review, that we passed around earlier, every 90 to 135 days to check in with the client. We do treatment plan updates during care. They're episodic, but

you know, any clinician will tell you that there's a lot going on between the 90 and 135 days. It's not just -- that's just the regulatory requirement, and then at discharge or completion of treatment, we do the CSR one more time, the client status review, to be able to measure our progress with a ton of data that shows progress from when they walked through the front door to when they walked out and we can actually use -- because the client status review is developed in-state, we compared it to the behavioral health risk factor surveillance survey, the BHRFSS, and so we can compare clinic population to general population, which is helpful for a state planning effort.

The individual gets discharged. Some folks are doing a follow-up survey, follow-up check-in. That's really on the providers themselves. There was an effort recently that is trying to look at some of the longer-lasting effects of treatment, and finally, we do something called the behavioral health consumer satisfaction survey to check in with the client, kind of on a customer service-related level to make sure that the services they received were respondent to what their need was.

MS. BURKHART: And so that episode of care is governed, not only by the clinical diagnostic information that Tom shared, but also by professional ethical standards. The fact that our service delivery system is person-centered, and

definitely from the Board's perspective, we tend to hammer that home.

Evidence-based practices, there's a registry of evidence-based practices. You've had presentations on evidence-based medicine. It's the same thing. We want our services to be culturally relevant, whether that's for our indigenous population or for folks from different immigrant populations, those kinds of things, trauma informed, and we're going to talk about our work with trauma informed care as one of our areas of success.

The services need to be accessible. That's not just that your building needs to be accessible, but they need to be accessible culturally, language-wise and disability-wise. A big gap for us is folks that are hearing impaired, finding ASL translators and then American Sign Language translators that are certified to be medical translators is almost impossible.

We are a recovery-oriented system and so that episode of care is always focused on the person's treatment goals and recovery. We believe that services delivered as close to home as possible are the way to go. So we're a community-based services system and holistic care, ensuring that as much as possible, the whole person is served and not just from the neck up. Next, do you guys want to talk about this?

MR. WALL: The field of behavioral health is constantly in a state of continuous improvement. We do that by, as we

were talking about earlier, collecting and analyzing data, both for treatment, prevalence of issues across the spectrum. We look at individual providers and geographical areas and culturally relevant issues.

One of the issues we address at the end of the presentation is the desperate need we have for providers in the workforce, especially at the specialty level for different levels of care. That's something that comes into this accessibility thing, as well.

We require service providers, most types, to be nationally credited. So they receive some sort of oversight and meet professional standards. There's ongoing workforce training, continuing education that happens in every grantee's program, certainly at institutes like API, and all professionals that are licensed, of course, have the continuing education requirements as well.

Then we, both practice and look for innovations in care, both to bring down cost and also to make services more available to people across the state. I'm being brief.

MR. CHARD: So now, the two, specifically, on this slide that I think are important for Commissioners, the accreditation thing is new. That was a requirement as of December 2011, the integrated regs. In your binder for back-up material, you've got each of the providers and on the bottom, you see their little accreditation stamp, whether it's

CARF or the Joint Commission or the Council on Accreditation or another one that meets the standards as outlined in the state regulations.

Accreditation is an extremely expensive process, one that was mandated without funding. Accreditation is a very time intensive and labor intensive process. To become accredited, you've got to go through a very large -- long series of steps. You get site reviews. You have to -- there's a lot of paperwork that goes back and forth, and then to maintain accreditation is also very labor intensive, work intensive, but I think that keeping up with the national standards, and particularly from CARF, Joint Commission, COA, these are the main players in the country.

These are the ones that are kind of the gold stamp, if you will, and so for them to come in, examine our providers and say, "Yes, our providers are meeting the national standard for quality," is a big deal.

The other thing that I wanted to point out real quick, just so it doesn't get buried in the slide is the same day access project. This was great. So the Division of Behavioral Health and the Behavioral Health Association teamed up a couple of years ago, because we were hearing a lot of problems with same day access to services.

There were wait lists. There were issues getting in to see folks and so half a dozen of our providers raised their

hand and said, "Yeah (affirmative), we'll transform our business practice to look at this. We'll go down that road," and they worked with the National Council on Behavioral Health and really kind of went through their -- from the front door, through their revenue, through their back shops and looked at how can we improve our service delivery and make same day access available to clients?

The results of that were phenomenally successful. It actually did produce the same-day access availability to clients. It was transformative in the process. It streamlined the process and it actually helped some of the organizations that improved. That was six providers of these 72 that you have.

I'd love to be able to scale that project up. Unfortunately, I don't have the funding to do that, but -- sorry, something's caught in my throat -- but that's the types of things that we're talking about with continuous quality improvement and innovation.

MS. BURKHART: So we're going to move into things that the system is doing well, because it's important, I think, especially from our positions, we do a lot of focusing on all the things that are wrong that we need to fix. So it's important to talk about the things that we do well.

So you've heard about the telemedicine program with the veterans system. We have a very robust and longstanding

system of telemedicine in Alaska. The Tribal Health System, and Xio will talk about that, has been offering telemedicine for almost 15 years and for behavioral health, Alaska Psychiatric Institute coordinates a telebehavioral health service for outlyers. So Xio and Al will talk about those briefly.

MS. OWENS: Yeah (affirmative), so AFHCAN, and I'm glad you guys put the acronym on there because I always forget what it is. So the Alaska Federal Health Care Access Network is housed within ANTHC and they have some innovative approaches to providing telemedicine, telehealth services and it isn't just that they purchase technology and equipment and get it out to the system, but they are actually like developing their own technology and their own systems that are unique to Alaska and are able to connect people across our vast state and so while it's housed at ANTHC, what they do is they work with every Tribal Health organization to make sure they have the equipment and for different levels of providers, too, whether it's behavioral health, community health aides.

They've got these little telehealth carts, that you know, you can connect with your medical provider and show them what you're seeing on the ground in the village and be able to consult with them and have full access to services just through a TV, basically. I really simplified that. I know it's much more complex than that, but in behavioral health, we

use it for, as I mentioned before, psychiatric evaluations.

It's used on a daily basis for therapy, to provide therapy from a clinician in a hub to a village. They use it for supervision and they also use it for training. So it's something that, to the best of our ability, any way that we can connect with folks throughout the state, we are always using telehealth.

MR. WALL: So for our piece of data at API, of course, there's a -- sir.

COMMISSIONER CAMPBELL: Question, in the villages, when people show up for these telemedicine site sessions, is there any kind of stigma that follows that in knowing that everybody knows everybody in a community like that?

MS. OWENS: I think that extends beyond just the telemedicine thing. The stigma of behavioral health in villages is difficult and while we're working toward integration, that doesn't just -- in a way, it can start with co-location, but often times in our villages, you've got the behavioral health center that is all the way across the village and it's obvious that if you're on that road, you're going to behavioral health, and so that kind of prevents people from wanting to seek assistance.

We, at ANTHC, we also, you know, we work to make sure that those settings are in -- where the equipment is, that it's in a secure and confidential setting. Sometimes our

clinics are not very -- not very sound, I guess. They might be in very old facilities and so we've had to work around that. We've had to find either -- which -- I mean, that can drive cost up, too, because you've got clients who, "I won't go to the clinic because I'm in a setting where other people can hear where the TV is coming from," and so at ANTHC, they try to make sure that those settings are secure, so that isn't an issue, but there are many ways that we try to address that, but I think that stigma is certainly something that can put a barrier up for folks, yeah (affirmative).

MS. BURKHART: One example of the Alaska Mental Health Trust Authority's advocacy is their relationship with the Denali Commission allowed them to require that when they were rehaving or building village clinics, they included a room for behavioral health visits with the itinerant counselor and telemedicine. So again, there are all kinds of issues with sound proofing and all, but that's an example of how the Alaska Mental Health Trust Authority uses its position and its capital to benefit the beneficiaries that it serves.

MR. WALL: And our piece of telehealth, telepsychiatry at Alaska Psychiatric Institute is quite critical. As we discussed before, there is a shortage of specialty care provider and the state psychiatrists are one of those specialty care providers. I happen to have the highest concentration of those at any one location and so API being

kind of the anchor of psychiatric care on one end of the spectrum of care, they provide consultation and services through telepsychiatry in a growing way across the state and we are, you know, actively pursuing relationships with multiple organizations to get more and more people onboard with that.

One of the primary areas that Xio mentioned a lot of, the different services that they can provide, one of the ones that I see as critical with telepsychiatry is just that medication management piece. So if you have a person like I described earlier who is stable on their medication and they live in an area where they don't have access to a psychiatrist, but they can go in and meet them through a telepsychiatry appointment. They can get their prescription refilled and go on their way. That's absolutely critical to maintaining the stability of these folks and providing care for them in a meaningful way.

MS. BURKHART: So the effort to ensure that Alaskans receive trauma informed behavioral healthcare has been going on for at least 10 years, but is right now, I think, probably reaching critical mass. One thing to remember is that trauma occurs to children and adults and it is regardless of social status, ethnicity or gender.

There's a lot of conversation in the state right now around adverse childhood experiences and the impact of adverse childhood experiences on both health outcomes as adults, as

well as social outcomes, like employment and education. We have a significant focus on folks that have experienced combat-related trauma returning from deployment, domestic violence, and all of those things contribute to poor health outcomes, not just behavioral health outcomes, but physical health outcomes.

The trauma informed care initiative has involved both the tribal and the state-funded systems. The tribal system has really moved forward efforts to recognize and address historical trauma. The Division of Behavioral Health has invested in trauma informed care training, ensuring that the experts in the state, primarily from the Child Trauma Center at the Anchorage Community Mental Health Center, provide training to clinicians statewide, so that they are providing the best quality service as possible.

We also have an initiative with the domestic violence emergency services community as part of Governor Parnell's Choose Respect initiative that has allowed for greater access to behavioral health services for victims of domestic violence.

MR. WALL: And if I may, we have until 10:00? Is that correct?

MS. ERICKSON: 10:30.

MR. WALL: 10:30, all right. I -- to me, one of the more critical aspects of this presentation is toward the end, which

are these three case studies that I'd like to talk about, because I think the focus of the conversation we're having is both on the level of care and the types of services that we have, but also on the financial impact of that and I think the case studies are particularly important in discussing cost.

So I do -- I don't want to be rude and just skip over a whole bunch of stuff, but I do want to make sure that we get there at some point today. Okay, we'll get there. I thought we only had until 10:00, so I was panicking, sorry.

MS. BURKHART: So these next two slides are about the Behavioral Health Aide Program, which is really one of the triumphs of Alaska's Behavioral Health System, thanks to the Alaska Native Tribal Health Consortium and the tribal health organizations, as well as the Rural Human Services program that the Department of Health and Social Services supports.

MS. OWENS: So I've talked a bit about the Behavioral Health Aide Program, as I talk about behavioral health services in the tribal health systems. So this slide just kind of gives you a little bit of background on who behavioral aides are.

It's modeled after the Community Health Aide Program, if you guys have heard of CHAPs, community health aides, village-based providers that focus more on the medical side of things. The CHAP program, initially, was begun in the 1960's in response to high TB -- a TB epidemic, high infant mortality

rates and then just high rates of injury in rural Alaska and again, noting that often times, you don't have higher levels of providers in small villages, there were many people who were based at the village who wanted to be able to serve their community and so working to train them to provide kind of that initial level of service and then also train them to know when they need a higher level of service and how to connect their patient or client with those services, and so following the major success of the CHAP program, in the '80's, there were a couple of pretty key reports that had come out that really documented the need for more village-based behavioral services throughout Alaska, and so the Tribal Health Directors charged ANTHC with developing a model that followed the CHAP program that was focused on behavioral health and so actually the next slide there.

So not only does this, you know, the workforce is developed to address the behavioral health concerns in the village, but also to have greater access to resources by enhancing the workforce across the continuum of care and so BHA's, they are village-based. Often times and the majority of them are of the culture. They are from those communities, the majority of the time.

Many of them are older and they've had their own life experiences. Often times, this includes their own experiences with some (indiscernible) and their ability to kind of

overcome those and they have come into this field because they want to give back and they want to help improve the health of their own community members and so again, following the model of the CHAP program, this is a certification.

So there are four levels of BHA, BHA1, 2, 3, and practitioner, and at each level, they have a pretty stringent requirement of different trainings to complete and often times, people look at what the requirements are up until behavioral health practitioner and they're like, "Gees, I could have a Master's Degree with all of the training that I have to do," but again, it's really preparing them to be able to recognize and intervene in and also inform their communities about issues related to behavioral health.

I also -- I won't go too much into it, but again, if you're familiar with the CHAP program, CHAPs have a document that's called "Community Health Aide Manual," and in that manual, if you've ever gone in a village to go see a CHAP for a medical appointment, they will always bring out their CHAM, and the CHAM is -- it's built kind of on an algorithm, you know, if this, then this.

If you come in with a cough, okay, go to the section on cough, and it will walk you through what all you can do and how to evaluate and provide services. It's much easier with the medical model. Broken arm, you know, you put it in a sling or whatever you do. It's much more difficult with

behavioral health, but we also felt that it was important for our BHAs to have a resource that was similar to that, especially because often times, BHAs don't have their clinician right there in the village with them.

So we recently -- well, not recently developed, over the past five years, we've been developing the "Behavioral Health Aide Manual," also known as the BHAM. So I will hand that around. It recently just go approved by the CHAP Certification Board and so BHAM, and so we will be getting that out to our behavioral health aides. There's, as you flip through it, you'll see there's a lot of great introductory information up front that is fundamental for behavioral health, but then in the back side, there are client care chapters that -- and this one, specifically, is for children and adolescents, but it should be a great resource for our BHAs, jut to continue to enhance them, so.....

MR. WALL: And I will tell you just real quickly, that this is a nationally recognized program of excellence in innovation. I read a great deal in the field of healthcare, obviously, and I've seen reference to it in a couple of different books that I'm just reading along and had no idea it was going to come up and then I also read a book on my way to D.C. two weeks ago that did a whole section on this program and kind of touted it as the national excellence and then I ran into a person at -- in D.C. who was talking about it and

thought it was the most wonderful thing in the world. Of course, they had not been to Alaska, but that's.....

MS. ERICKSON: Is it -- I'm sorry, is the BHAM available online or could we buy a supply or a copy, at least, for.....

MS. OWENS: It's not available online and we're actually in discussions about how to kind of get it out to other people, if they're interested in purchasing a copy. So I can -- we can follow up and see how to get a copy to you, absolutely.

MS. ERICKSON: Thank you. It's exciting.

MS. OWENS: It is very exciting.

COMMISSIONER STINSON: Like a lot of things in medicine, this sounds excellent. Do you have any outcome studies yet? Has this resulted in any change of people having to go into town or progress up the continuum? Is this resulting in things you can document?

MS. OWENS: Right, great question, and truthfully, I think that we're at a place now where the BHA program is still fairly young. It wasn't put into the standards from the CHAP Certification Board until 2008. So with that said, no, we don't, but we are also with the BHAM having come out and also with ANTHC recently being given approval to develop a BHA training center, if you guys are, again, familiar with the CHAP program, they have a CHAP training center. There's never been a BHA training center and as a part of that training

center, we're required to gather data about kind of the progress of BHAs and whatnot.

So I would hope that those things will be coming out in the near future, and again, also, there's a process for becoming an evidence-based practice and through, is it through NACE, or maybe they change their name recently, but there is a process for developing a program and evaluating it so that it can become an evidence-based practice and so we've been looking at for the BHA program, too.

MR. WALL: And there is research on the CHAPS program and it's well documented and it is made up of the same model.

COMMISSIONER STINSON: My mother-in-law is a CHAP and I could talk to you about it.

MS. BURKHART: Great. So we've included two slides on one of our prevention successes, which has to do with underage drinking, and while our presentation is focusing on the adult system, the reason we included the success we've had in reducing underage drinking is because there's been quite a bit of research that shows the younger a person is when they start using alcohol, the greater the likelihood they will be addicted or dependent on alcohol as an adult and we have managed to reduce the number of youth saying that they had a drink of alcohol before the age of 18 to about 15%, and when we started, it was more than 35%.

So if you go to the next slide, you'll see a chart that

shows the decrease in youth alcohol use among traditional high school students, and what that means is, several years ago, we added alternative high schools to the way we collect this data and up until then, it was always just mainstream high schools like West or Juneau Douglas.

Now we include alternative high schools, but we parse that data out differently, mostly because that's our highest risk student population. So this is mainstream high schools and the youth are reporting a significant reduction in alcohol use in the last 30 days of the time when they were asked the question, and this is because we have consistently invested in underage drinking prevention.

We have had a state plan and a state plan update. We have received federal, as well as state funding for this effort and it's comprehensive. It is not just, "Say no." It is a comprehensive approach to ensuring that students have all of the assets and resiliency factors they need to make good decisions and so it's a very -- comprehensive is the word, way of going about prevention.

MS. ERICKSON: Do you have a similar slide that shows how use of other illicit drugs tracked over time?

MS. BURKHART: We do. In fact, my office has about 100 slides of YRBS data that I'm happy to share.

MS. ERICKSON: So that -- does that track in the same direction or.....

MS. BURKHART: So illicit drug use for things like cocaine and heroin have remained small and relatively flat. We are seeing an increase in heroin use. Marijuana use has not had the same decline in use that alcohol has, partially because most prevention efforts haven't focused on that.

I do a health class for the Kenai Borough every year for their Distance Delivered Health for high school students and I focus on use/substance abuse, and every time I deliver the class, when we get to the marijuana slide, I ask them, "Why do you think this is? You saw the alcohol slide went down. Marijuana didn't," and inevitably, they tell me, "Well, marijuana's not bad for you," and so that's information for prevention specialists to understand that might be contributing to why prevention efforts are not working.

Next. Going all the way back to Dr. Hurlburt's question about his efforts to use case management and care coordination to reduce cost, integration of behavioral healthcare and medical care, we've been saying primary care for the last like four years and now Tom tells me it's medical care, is a great way to improve patient outcomes and reduce cost, especially when you look at the intensity of comorbid conditions, like asthma, and COPD, coronary heart disease, diabetes, and hypertension, there are multiple efforts to move to patient-centered health homes or patient-centered medical homes.

Southcentral Foundation and the NUKA model is an example.

Both the Department of Health and Social Services and the Primary Care Association are invested in figuring out how to best implement patient-centered medical homes in Alaska. So we're hopeful to see something groovy come out of that and we also see on a smaller scale, behavioral health centers and primary care practices moving toward various levels of integration, whether it's co-location, more intensive referral and care coordination or full integration. I always get their name wrong in Kenai, Peninsula Health?

UNIDENTIFIED SPEAKER: (Indiscernible - too far from microphone).

MS. BURKHART: Peninsula Community Health used to be a community health center and a behavioral health center and under the leadership of Stan Studman at the behavioral health center, who was also very active in the Primary Care Association, I think I got that wrong. I think you said the Primary Care Center. Anyway, they became one of our first fully integrated organizations.

They became a new nonprofit. They built a new building that was designed to facilitate integrated care and so in Alaska, we have a wide range of practices and organizations that are using this to increase the quality of care and reduce the cost.

MR. WALL: I'll speak just briefly to that. So we do, as a Division, has an emphasis in this area. We've been working

on it for a number of years. It is difficult to implement, as many of you are physicians, you probably know better than I that in a clinic, it's difficult to integrate this. The clinic she's talking about in Kenai does have an LCSW on staff now and we're working in that direction as best we can to assist them and fully integrate it.

There is -- there are models, especially down south, that have what you would call integrated care. In my experience, they've been more like partnership care. They still have two separate systems where the mental health person does this and it's completely, you know, detached from what the medical care does.

We're interested in an actual integrated care model, which integrates medical care with behavioral healthcare in a plan of care, which is important. So I don't want to belabor that.

MR. CHARD: Well, and the Health Care Commission has received a million presentations about patient-centered medical homes, integrated care, and it's been included in your reports. I did want to point out on this slide, the four quadrant model and so this is really talking about where folks are and where they best could be served.

So it's no surprise, if you've got a major physical health problem and a minor behavioral health problem, it's probably best to be seen in a medical care environment. If

you've got a major behavioral health problem and a minor physical health problem, it's probably best to be seen in a community behavioral health center.

So you know, the four quadrants kind of -- that's where the people land. In the behavioral health side, you know, a lot of attention, I feel like, has been given to integration, kind of leaning on our primary care partners and friends. The challenge from the behavioral health side is a lot of the funding and attention just isn't there.

So it's a great idea and we try to bring in nurse practitioners to do certain things. We try to do bring in primary care providers to do certain things and we've got great examples around the state of that kind of collaborative partnership, but the ongoing sustainable investment in the system, to make that system transformation, at least on the behavioral health side, we haven't seen that as much nationally, as we have on the primary care sides, examples like North Carolina and places like that, and I think that a lot of that is coming from the managed care perspective, which of course, we don't have here, so -- in that vein, and so that's at least from my side, from the behavioral health provider side, what we're seeing.

MS. BURKHART: Next. So now we get to the case studies. So we thought, after all the blah, blah, blah, it would be good to walk you through the actual experience of people

receiving behavioral health services, and so what we did is we created three individuals that are representative of the worst case scenario, the mid-case scenario, and the best case scenario, and then we looked at actual Medicaid claims data for people that were similarly situated to our made-up people.

So these are not the-name-has-been-changed people. These are made-up people and then we looked at our Medicaid data to figure out an idea of what that person would cost. So the first person, and so how we're going to do this is we're going to start with the story and the person, and then we'll hear from Al how the state system is implicated, Tom and Xio, how the provider system is implicated.

So our first person is John, who is from a small village in the Bristol Bay region. He's Alaska Native and he just turned 24. Throughout his childhood, he lived in an environment with domestic violence and parental substance abuse and his dad was in prison a lot of the time. So he has three adverse childhood experiences. Three to five is where you see the most significant health problems, social problems as adults.

When he was 23, he went out fishing for about three weeks in the summer and he came back, extremely withdrawn, not his usual self, sleeping in the shed, not in the house, and it eventually escalates into a psychotic episode where he tries to kill his grandmother.

So the Troopers have to be called. He's transported to API. He stays there for 10 days to get stable to deal with what's going on. He gets a diagnosis and then he goes home and part of going home was a discharge plan that included connecting with the Tribal Health Organization for behavioral health services.

John is no longer incompetent and so he chooses not to engage. The behavioral health aide in the village checks in once a week, talks to his grandma. He's having none of it. The itinerant counselor comes to town, tries to engage. John is having none of it and it actually makes things worse.

Because of the fact that John is not engaged in services, he -- his condition continues to deteriorate to the point where he develops a fixation on the clinic because that's where the behavioral health aide and the itinerant counselor are coming from and they keep bothering him and he burns the clinic down.

This has never happened in real life. It's a made-up story. So luckily, no one is killed. The Troopers come and John is now in corrections. He's been convicted of arson and he is in a secure mental health unit in the Department of Corrections. Go.

MR. WALL: Go, sorry, I got a chime in the middle of that. So what we want to do is not only track the -- where the client intersects with services, but also, then who pays

for those services and what type they are. So when the Troopers are called, of course there's a cost associated with that when they transport the individual to API.

What that looks like is API has a provider called WECA (sp) that we contract with that will fly out and get the individual and bring them in. The transport cost is provided by straight general fund under the DET program, which is Designated Evaluation and Treatment. So that person is brought in at that cost that's on the sheet. It's about $3,000 for that one, $3,210.

They go to API and they get their competency evaluation and they're stabilized there for, our scenario was 10 days. So the total cost there is $17,756, which is the average cost of a 10-day stay there.

When he's returned to his setting, he's on medication and that cost is covered by the Bristol Bay Area Health Corporation clinic, which is IHS. So that's federal. Of course, he doesn't stay on his meds and decomps again and ends up going through DOC and so the cost is there, as well.

MS. BURKHART: And that DOC figure is from 2009. I think that's right, and it was reported by the Justice Forum at the University of Alaska Anchorage.

MS. OWENS: I'm not sure what more you'd like for me to contribute to it. That's a pretty accurate depiction of what happens.

MR. WALL: Yeah (affirmative), that's a good setting and that's, you know, that's a fairly.....

MS. BURKHART: Dismal.

MR. WALL: It's a dismal outcome. It's horrible.

MS. OWENS: I'm sorry, the one thing I would add is in situations where this, maybe not the burning down of the clinic and whatnot, but when someone does have, if they have a psychotic break in a village setting, the resources in the community that it takes to be able to keep that person safe until the Troopers get there can vary and sometimes that means that if they do happen to have a jailhouse there, that person is housed in the jail until the Troopers get there.

If they're able to have someone in the community who that person feels safe with and that they can monitor them, they stay with that person, but they don't have, like psychiatric beds at a clinic where the person can be kept and maintained and stabilized until additional supports get there, so -- and then, again, when we talk about being weather-dependent, that could be a few days.

So I don't want people to think that it's like, they've had a break and then Troopers are there within a couple of hours. I mean, this can take a few days, and if you can imagine the things that kind of come along with that.

MR. WALL: But if you think also in terms -- just keep in mind that there are many other costs associated with this

individual. So when they go to court, there's the court costs and there's the attorney costs and there's, you know, the hospital costs. There's all kinds of costs that are associated with this person that are coming out of the public system to service one individual.

MS. ERICKSON: Yeah (affirmative), I was just going to point out that your cost estimate doesn't include the cost of the Tribal Health System of the behavioral health aide service.

MR. WALL: Right.

MS. ERICKSON: And I should also mention that there's about 10 minutes left and you might want to leave time for a few questions.

MR. WALL: Okay, sure.

COMMISSIONER HIPPLER: In that case study, was John addicted to anything?

MS. BURKHART: No. That's just a straight psychotic break. So in the interest of time, you've got your second one, which is our middle range and so we're going to just jump to our gold-plated, this is what we would like to see happen with folks.

So Joe is 22 and he lives in Juneau and he has been in the behavioral health system since he was 14. So he was diagnosed with a serious emotional disturbance. He received the full suite of services as a young person, did extremely

well. The transition to adulthood did not go well.

He -- often that happens because you're moving from complete wrap-around services to, "Yay, you're a grownup and you're on your own." So Joe is a Tribal Health beneficiary. The Tribal Health Organization was able to provide some services, including med management, but not the full suite of rehabilitative and support services he was used to and so his transition did not go well.

He began to self-medicate with marijuana. He started to decompensate and began to have problems, like he lost his job, which meant he lost his housing and was couch surfacing. His family, who had been engaged in his treatment regimen throughout, quickly worked with him and the community to get him into services at the community behavioral health center and they were able to resume that full suite of wrap-around services to get him stable again.

In this case scenario, it took about a year. You see that full suite from diagnostic interview to clinic and rehab services to medication in the first year. Most of that is general fund and federal, whether through the Tribal Health System or this recipient is Medicaid eligible, because he's been disabled since he was an adolescent, and then you see in year two, once he's stable, he's able to manage with just group psychotherapy and his medication.

The $24,200, that's the highest end pharmacy that we saw

in our Medicaid study from 2009. Some folks, it's more like $4,500 a year, but we were trying to show this kind of gold-plated way of providing services. This is also an example of how recovery is dynamic. This is somebody who with four years of services was good to go and then for a lot of reasons, it didn't work out and the quicker we jump in and resume services and achieve stabilization, the less severe social consequences we see.

We didn't see chronic homelessness. We didn't see a long period of unemployment. We didn't see violence. We didn't see those kinds of things.

MR. WALL: So from the funding side of things, if you look at the cost associated with him underneath the years, again, this is the tributary river thing and if you just think about the episodes that he went through, it is likely that the initial psychiatric diagnostic interview and some of the individual psychotherapy occurred at the tribal setting, because that's where he was eligible initially.

When he moved into a more community non-tribal setting for care, his care was likely provided by a combination of general funds through grants from the Division of Behavioral Health and also through Medicaid. If the individual in our scenario is -- has been determined disabled, he's likely receiving SSI and therefore, probably on a waiver of some sort for Medicaid and some of these services would be provided then

through Medicaid at a match.

So if you look at the cost, you know, some of those are associated with IHS. Some of those are associated with the grant funding dollars and some of those are associated with Medicaid match and it's hard, unless you look at each individual claim, to know which one comes from where.

MR. CHARD: And so the Behavioral Health Association has providers that are both Tribal Health providers and non-Tribal Health providers and so one of the issues that we, as a state, and providers are constantly struggling with is the service availability within the Tribal Behavioral Health system and what Tribal Behavioral Health can do for a client and what they need to go to the, maybe the community behavioral health setting for.

From a state's perspective, and I think more germane to this group, what you guys should be hearing in this example are 100% federal match for an IHS beneficiary served in a Tribal Health setting versus a 50% match in a non-Tribal Health setting. So when there's a 50% match, that means the other 50% is coming out of general -- the state's general funds. So it behooves us to try to support and develop our Tribal Behavioral Health System as much as possible so that the feds are picking up the dime, basically, instead of it coming out of our state's GF.

MR. WALL: So at the end of the presentation, there are a

couple of slides that have challenges associated with them and then, kind of what we're doing in the behavioral health field to address those challenges and I'd like to, you know, give you an opportunity, obviously, to look at that and field questions, but I also see that we have about four minutes left. So if you have a question that you would like to ask anybody on the panel, feel free to do so, and we have also provided sites for additional information and our email addresses and you can certainly visit the websites.

I know the Board's have a tremendous amount of information, data-driven, on the web. We have some in the programs there, as well, but if you have any questions, feel free.

COMMISSIONER CAMPBELL: I know that you're probably short of clinicians around the state, like everyone else. Are you in the recruiting business as an umbrella organization or how do you handle that?

MR. WALL: Are you speaking to the Boards or.....

COMMISSIONER CAMPBELL: I'm speaking to the individual -- you have a client base and you have providers in different areas, how do you recruit? Do you let each individual provider go out and recruit or do you do it under some sort of an umbrella?

MR. WALL: Well, I'll address that from the behavioral health perspective and then let the Association and the Boards

speak to that. We do have providers, of course, and they are responsible for recruiting their own. However, often times, I'm asked by a mental health clinician, who's looking for a job, you know, where they can find a job. I get solicitations from people out of state who just want to move to Alaska, and you know, I try to point them in the right direction on that.

I am also generally an advocate for recruitment and I speak about it often when I'm at -- in a setting to do so. I'm often, you know, in a college or with people that are in training or even young people who are looking into the field.

I, in particular, being from Alaska, really like to recruit from within. I think it's critical that we have people that are here that understand the system and what they face. I do think there is, obviously, benefit from bringing people in from the outside, but I do everything I can to recruit internally. I know that the University of Alaska and Alaska Pacific University both have programs in behavioral health, clear up to the Doctoral level. They're doing a tremendous job in effecting that.

One other thing I'd like to point out is we've had a great success at Alaska -- the Alaska Psychiatric Institute through things like the Sharps Program, where we can bring a psychiatrist onboard from out of state who's a very specialized care provider and then what's happened in 80% of the time, is that they stay in-state, in particular, those

that are going through the nursing programs or through the clinical programs at the universities and they do a rotation through API, they stay in-state. The statistics are that they stay in-state and take up full-time work here. So that's a good thing.

MR. CHARD: So from the Behavioral Health Association's perspective, it depends on the level of workforce that you're talking about. For specialty high-end folks, Alaskaphysician.net, I believe, is one of the places where shared recruitment is available. We participate in the Alaska Health Workforce Coalition efforts, which is kind of a collaborative kind of a thing, and I actually sit on the SHARP Council, which is the Loan or Payment Direct Incentives Council, and so there is some collaborative effort, particularly at the higher-end.

We've also, as Al mentioned, had really good success and growing success with rotation programs for higher-end folks. For the mid levels and for some of our direct service workers, a lot of times the recruitment falls on the individual agencies. The direct service workers, there's kind of -- there's an effort to look at adequate compensation to try to address that, to try to address the core competencies training.

A lot of that workforce development was formerly through the Trust and has been more recently, with the Alaska Health

Workforce Coalition, in addition to the Trust's workforce focus area. So it depends on the level and the Behavioral Health Association is great, because it's all the directors from all the organizations and a lot of times, you know, if somebody, particularly from out of state, is interested in, you know, a certain position or a certain job, they're good about communicating that through the Association to some of the other providers.

MS. OWENS: So recruitment in the Tribal Health System often times -- every organization, they kind of take their own lead on recruitment, but ANTHC, as a statewide supporting organization, we also can help with the recruitment of clinicians.

A part of the challenge that we have experienced and continue to experience is turnover in the workforce. It's pretty significant and that leaves for gaps in service and access to service. Sometimes, the challenges come from people, you know, if we do kind of a national recruitment type effort or people from the Lower 48 become aware of a position that's open, they see a dollar amount and that dollar amount doesn't -- to me, it doesn't really translate to the same from the Lower 48 to being in a village.

The cost is associated, you know, cost of living, access to resources, but also, I think sometimes it speaks to the challenges of what you're presented with when you're there.

Some of the turnover happens a lot because of secondary trauma. When you're living in that setting and you can't really get away from it and you're constantly faced with the challenges of behavioral health in a village setting and so someone might go there because they're attracted by the dollar amount or all of our -- the TV shows about Alaska, you know, it's a great place to be, but you know, when you're living in that and you're constantly faced with some of those challenges, it can be really difficult and so -- and also, having folks be -- it's one thing to be able to, you know, deal with the weather and distance, you know, from other people, but when you are in a culture that is different from your own and you're not prepared to be able to navigate that, that can be really challenging too, and it can also be very isolating, because if you're not accepted or embraced by that community, you're not going to be able to provide the service that you initially had gone there to provide and so I -- a part of our recruitment efforts, and maybe some of this is just me, as an Alaskan and having come through the programs that are available here, there are some major efforts to kind of grow our own and a part of that comes from supporting BHAs in getting their college degrees.

We would love to be able to support them up through the Master's level. They're the people who were there clinicians came. They'll be there after the clinicians come and so being

able to support them in being in those positions is a pretty significant effort, but also, I have worked really hard to try to develop programs that offer more opportunities for people who are coming through the training programs here in Alaska to have some of that training out in rural settings in the Tribal Health System so that they understand it, but again, as statistics show, where people complete their internships and whatnot, they're more likely to stay there. So if we give them some opportunities to experience it and train within it, not only are they prepared to address those issues, but they might actually stay.

MS. BURKHART: And some of our communities, to address the need for psychiatrists, have, with varying degrees of success, worked together to recruit and then share the resulting hire. That's been done in Juneau, and Fairbanks attempted it, because they are in dire need of psychiatry in the public sector and while in Fairbanks, it didn't achieve the result they wanted, it was a significant step that the hospital and the community behavioral health center and several other agencies all said, "Okay, we're going to do this together and then we're going to share the person."

In Juneau, the hospital has recruited the psychiatrist and the community behavioral health center shares the psychiatrist. I think some cost issues have arisen there, but that's an example of how there is collaboration in recruitment

in some communities when there's a really dire need.

COMMISSIONER URATA: Do the BHAs, are they able to get a degree from UAA in the pursuit of their BHA training? They actually can get a Master's?

MS. OWENS: Yeah (affirmative), so as I mentioned before, the BHA program is a certificate program, a certification program, and so with their training requirements, there's a couple of ways they can get those training requirements done and some of it, you know, one way is there's a list of courses. If you complete those courses, that meets that requirement, but the other way, the alternate course of study allows for someone to use like a college degree like from rural human services on up through AAS, Bachelor's, Master's Degree.

So it depends on -- and some people aren't interested in having a degree and so they're okay with completing those individual courses. Other people are really interested and there are many benefits to that, including being able to have, you know, work all the way up to the Master's level and be a clinician.

CHAIR HURLBURT: What grade level did you write the manuals at?

MS. OWENS: I actually don't think it has been evaluated, but a part of -- to establish like a firm grade level. It is -- it does have some pretty technical content in there, but

when we developed it, it was developed with BHAs sitting at the table and so often times, the content would be written by a clinician and then reviewed by and have feedback from a BHA saying, "Is this language that you understand? Is this the kind of terminology that you would be able understand and then translate that to an individual that you're working with?" So I guess that was kind of our way of evaluating the content that's in there.

CHAIR HURLBURT: Yeah (affirmative), in, you know, and over the years, Native kids have gotten -- been able to go farther and farther in education, both post high school and earlier, but in the earlier editions, I remember the community health aide manuals, they were clearly written at a much less sophisticated level.

I was impressed that this was at a fairly professional level and maybe that's totally appropriate now with the kids that are getting more education, but it would have presented a challenge, at least at the time of some of the earlier community health aide manuals.

MS. ERICKSON: Questions?

MR. WALL: If there's -- I want to make one offer before we go, if there's no more questions. If you have interest in this area and you'd like to see more or talk more, I will make myself available and I'm sure everybody up here, as well, but I would go so far as to say if you'd like to actually see

more, I can certainly broker a deal between the Division and some providers to get you out into the workplace so you can see what they're doing.

I would invite you, if you have not been, to come by API and we'll give you a full tour. If you really want the full treatment, I'm trying to get some legislatures who would like to spend the night at API with me, because frankly, I'd like to have a few of them diagnosed, but they have really good food and I think it would be a tremendous benefit to learn the system and exactly what we're dealing with and the level of care that we're talking about. So please.....

MS. ERICKSON: Do you have a meeting facility in API right now?

MR. WALL: Yes. Yeah (affirmative), API.....

MS. ERICKSON: Could we hold a Commission meeting there at some point?

MR. WALL: Absolutely, yeah (affirmative).

MS. ERICKSON: I'm not joking, Ward, as long as it's free.

MR. PUCKETT: As the new Director, you might be careful saying broker a deal in public.

CHAIR HURLBURT: Okay, thank you all very much. This was very helpful and at some point, we will ask you to come back and update us again, because it is an ongoing issue, but we look to you all and your representative organizations being

the focal point for this day and thank you for what you do.

MR. WALL: Thanks for having us.

CHAIR HURLBURT: Thank you for sharing so generously with us.

MS. ERICKSON: So we're at the point of taking a break and let's be back in 15 minutes.

10:37:57

(Off record)

(On record)

10:54:12

CHAIR HURLBURT: Why don't we go ahead, I think we're all back. Jim is just out in the hall. He'll be coming back in. Deb was trying to coral us, especially Ward and Larry and Bob, and we must share some deficiency together, whatever that is. So that's what they call herding cats.

So we've come to our last session of the morning. We have, I think you'll find some of the material that Deb's going to talk about interesting and some plans and things coming up and then we'll talk about our next meeting some and wrap up and get feedback on this meeting and suggestions. So Deb, I'll turn it over to you.

MS. ERICKSON: And I wanted to start with apologizing on behalf of Commissioner Streur. He wanted to let -- wanted me to let you all know that it just -- this meeting, somehow got dropped off his calendar and he got double-booked and -- but

he really appreciates having an opportunity to come meet with you all and update you.

I'll be updating you on the MRAG and also -- the Medicaid Reform Advisory Group and sharing some of my plans to take some information from the Commission to them in just a minute, but I want to first just update you on the status of our initiative on the -- to develop the report on health and health care in Alaska in 2014, and then go back and revisit a couple of things we talked about yesterday and -- to provide a little more context for what we're going to be doing with the Medicaid Reform Group.

Then finally, Representative Keller, just in a little sidebar conversation yesterday, we were talking about public communication efforts around Commission business and so we can talk a little bit about some of the things we are doing and see if you all have suggestions for some additional activities. So that's how we will wrap up our day today and we will get out on time, so Dr. Stinson can go see his patients this afternoon.

So the -- just as a reminder, the Health and Health Care in Alaska 2014 initiative, this was something that we developed and took on without direction from you all and without having planned to do that this year, but it appeared to be too much of an opportunity for us when we realized that the only two reports that I'm aware that pull together a point

in time picture of both population health status for Alaskans and the state of Alaska's healthcare system had happened in the last 30-year intervals, in 1954 with the Parran Report and in 1984 with the last Alaska Statewide Health Plan that was developed by the federally supported health systems agencies and so we're making progress with this initiative.

I can't remember if I told you the last time that it was also a happy coincidence that there were other initiatives that were pulling this information together currently in bits and pieces, where it's not normally done. So the Health Alaskans just -- and I emailed out to all of you just a couple of weeks ago, the link to the new Health Status Assessment Report that the Health Alaskans initiative just released and posted online and so for our health status piece, we have a couple of sets of data tables showing 10-year trend data for 71 different health indicators and also, the 25 leading health indicators that the Healthy Alaskans Initiative has eventually selected and it kind of covers the gamut of physical and behavioral health conditions and also has a sprinkling of some key kind of social economic conditions that are more social determinants of health. So that's all available online right now.

I had sent to you all a link at one point, we created a web page on the Commission's website for this initiative and the two bullets I have up here on the screen right now with

our -- the timeline for the initiative and the bibliography that we're going to kind of be writing the umbrella report for, with all of those links, are posted online.

I've been working with the Department of Labor and they are producing a report for us on demographics and demographic trends and they're real excited to work on this project, too, and are already -- have produced very recently some pertinent materials that they'll pull together in kind of an umbrella report with one of the things -- just one example of one of the things I asked them to make sure is included in the report, is the demographic trends in the senior population, since that has a significant impact on our health system and they're actually going to be looking 30 years into the future for us, so not just looking back and looking at what the trends have been over the history of the past 30 and 60 years.

Then also, the State Division of Public Health, under the Healthy Alaskans 2020 Initiative, just recently went through an exercise to conduct an assessment of the state's public health system and we'll have a presentation on that, actually, at our next meeting as part of our Healthy Alaskans 2020 update, and they're producing a report that will include -- with our umbrella and then the healthcare delivery and financing description will be part of that. So I'm expecting those other three reports at the end of September. Yes, Dr. Urata.

COMMISSIONER URATA: As part of the public health system, are they going to predict or give us a little idea about future threats or needs?

MS. ERICKSON: That report will not do that. It's more descriptive of the current system. However, one of the things I didn't include here are three -- the three folks who I picked to be kind of expert advisors to me, who are all either current or former state health officials for the state, responsible for, essentially for the state's public health system, so Dr. Butler, and Dr. Monsager, in addition to Dr. Hurlburt, and part of the -- I'm going to be writing a summary of all of these pieces for part of our report, but the three of them are going to work on a commentary and we have a list of issues that they might address in that commentary and I think some of the future health threats -- are you thinking specifically about like the infectious disease threats and the ebola outbreak right now, that sort of thing or other.....

COMMISSIONER URATA: Well, what will our healthcare system have to deal with in the future that will have an impact on cost and stuff. Now, I know there are things that are unforeseen that you cannot predict, but you know, I don't really view ebola as something that, at this point, could get here.

It's possible, but you know, tuberculosis coming back, HIV, and then, you know, behavioral health, I think is going

to be a big public health issue in the future, because I don't think we have the answers, you know, despite the efforts of the three or four people that were here, I think that's going to be a major player in the future health of Alaskans in the future and that's part of what we're here to do. Our mission is to try to figure out a healthcare system that can take care of the problems and I think that's going to be, you know, the future.

CHAIR HURLBURT: I -- I think that, at least the three of us, Jay and Dick and I, as we've understood the vision and the challenge was that it was more a retrospective look, rather than prospective looking forward. So it was a different issue than that, but I think you're right. We need to be prepared.

I agree, based on everything we know now, ebola is a terrible human tragedy in West Africa and the habitat of the fruit bat, that's the host, goes all across central Africa, down to South Africa, up to the Sudan and Eritrea area, even over into Yemen a little bit, so a terrible threat there, but probably not here, but there are other things like you say.

Just my own personal belief is that should the Proposition 2 pass in November, the marijuana legalization, that we'll have some significant health impacts. Larry and I were just discussing that and I've talked with my counterparts in AASHTO about that and it seems like there's a train coming down the tracks and the more I have read about it over the

past year, trying to learn about it, the more convinced I am that there are going to be major public health impacts as we see this being more accepted in society, recreationally.

So I think -- yeah (affirmative), and the infectious disease, like you know, you and I have all lived through times when we thought, "Well, you know, now we're onto diseases of choice, smoking, the overweight, the obesity and so on," but we keep seeing infectious disease come along, like HIV, that we didn't know about in our younger days and wreak terrible havoc. So we can't say, "We've been there, done that," with infectious disease.

COMMISSIONER STINSON: Not ebola, but the new spectrums of the widely resistant bacteria, well at MRSA plus, they have the new enteral bacterial that are resistant to everything. At some point, that's going to impact on what we do, surgery, elective surgery, are people going to get knee or hip replacements, if you can't keep an infection from -- we might just go to basically surgery of need, because the risks involved, but that's speculation, but that -- if you're keeping up with Medscape on the literature, that is a concern shared by many as something in the future and that would impact healthcare to a significant degree.

MS. ERICKSON: So stay tuned, and the one other thing I wanted to point out to you, too, I had emailed this two-page description of the event that we're going to have with what I

was calling health historians or health policy elders, folks who were working in some sort of leadership position in healthcare or public health in the '60's, '70's, and '80's, who we're inviting to come have a conversation about what was -- what their experience was and what was kind of informing the issues that they were addressing in the day and so I hope you all will be able to attend it.

It's not a meeting of the Commission. It's the day before our next Commission meeting. It will be in the same venue, we're meeting in the Dena'ina Center in October, and for those of you who are able to come, this is going to be an event open to the public, but public members will be able to sit around the room and listen in.

The folks will have a facilitated conversation with them and Commission members will be invited to sit at the tables with them and to ask them questions. So if you can come, I hope you will be there. Yes, and that will be in the morning. The actual -- the agenda's on this two-page description, which is behind Tab 2 in your notebooks and it's also provided on the web, but we'll start at 7:30 with breakfast and get started at 8:00, and we'll wrap up at noon, but we'll have a luncheon and informal conversation at noon then. So I'm going to -- does anybody have any questions about this Health and Health Care in Alaska Initiative?

One of the slides I skipped over inadvertently yesterday,

that I want to go back and revisit, as we were talking about our process moving forward and the process that we'll use over the next couple of months and at our October meeting to identify priority recommendations that the Commission has made already that we would like to take and do some facilitation around implementation.

I suggested this at the last couple of meetings, just because we're not doing anything right now or if we choose not to do anything in the future around trying to advance any of the recommendations, doesn't mean that there isn't stuff happening already and it doesn't mean that Dr. Hurlburt and I are not being asked to provide additional information and guidance and so with or without a broader public process, that's happening behind the scenes, and trying to be as transparent and public as possible in what we're doing.

One of the things -- so one of the things I wanted to mention is that Legislative Elements Policy Paper Around All-Payer Claims Database, even though we're not having a stakeholder session where we might have, in part, spent some time inviting stakeholder feedback on that, I still intend to finalize it and release it at the end of this year and maybe we'll just release it still in draft when we do our public comments around our findings and recommendation, because it's already out in the public domain. It's available as a draft document and it is based on the learning and the

recommendations that you all made.

One of the things I wanted to point out, we hadn't shared in the past, and I included a copy of this document in your notebooks, again behind Tab 2, it's a letter dated August 5th from Dr. Hurlburt to the Alaska Health -- Human Resources Leadership Network.

They asked us a month or two ago if we could provide for them a description of the policy recommendations the Commission made -- has made that require legislative action to implement and so that's what this letter does. It's in response to that request and it's the one place, really, where we've compiled now, all in one place, a little bit of a description and a discussion of these different areas and so it's a seven-page letter and it includes as an attachment, our core strategies and policies recommendations document, but I would commend this to you and ask that you please read it, because I think it's real important and this is something that we will make available publically.

I'm holding off on posting it online with our handouts for this meeting or distributing it electronically until they have a little chance to absorb it, until I let them know that it's going to be shared, but their intent, they're actively working with legislators in trying to advance some of these recommendations. I mean, the whole reason this group, again, convened a year was over their concerns about healthcare costs

and the impact on their businesses and on the economy of the state and so they're interested in taking this forward and doing something with it.

MR. PUCKETT: Yeah (affirmative), I compliment whoever put that thing together because I was just thinking of some of the health -- human resources perspective and read it that way and it was perfect. I mean, it was very well written and if anybody here has not read that, certainly take a moment to do so.

COMMISSIONER URATA: Can we do a follow-up on a yearly basis with new recommendations and such? Is this an ongoing effort on communication?

MS. ERICKSON: Bob, if you could use your mic and I'm not sure I understand your question.

COMMISSIONER URATA: Do we do a follow-up letter next year?

MS. ERICKSON: Well, this letter was done at their request. So it would depend on whether they have a continuing interest, whether they still exist.....

CHAIR HURLBURT: But Deb and I are meeting with them periodically.

COMMISSIONER URATA: Okay.

MS. ERICKSON: At their invitation, yeah (affirmative).

CHAIR HURLBURT: Yeah (affirmative).

MS. ERICKSON: And actually, I don't know yet whether

they'll be able to attend. I should update you on another project, but for our October meeting, part of the agenda, our hope is to invite some business leaders for two different sessions, one to have a conversation with us about their reaction to our employer health benefits survey, and by the way, we don't have that final report yet from ICER. We're expecting about a 60-page academic report. I've also paid them a little extra money to produce a four-page summary report that's targeted at a non-academic audience for -- that will be more consumable for business leaders.

So we should have both of those reports by the middle of September, at the latest, and we will be distributing those broadly to the employer community, but would like to bring a group together to have a conversation with all of you about their reactions to that report.

In addition to that, we're hoping to bring some of the leaders of the HR Leadership Network to the table to have a conversation specifically about this document, some of their plans and their issues, their concerns, so that we'll have an opportunity to have a little follow-up more publically and you all participating in that conversation is our hope at our October meeting.

Any other questions or comments about that and some of this ongoing work, and I mentioned earlier yesterday, talked about number four on this list, the state agency action plan

for implementing the Commission's recommendations, which leads me in, if you don't have any other questions, to the Medicaid Reform Advisory Group.

I've got to catch up again. As far as the Affordable Care Act update, I don't have much to update you on implementation there, since we're pretty much, in this state, just focused on what's happening with the Medicaid Reform Advisory Group at this point. I thought I would just really quickly update you on the one change that happened in the past couple of months since our last meeting.

At the national level, in terms of Medicaid expansion decisions, it was one of the states, I think it was -- was it Utah -- New Hampshire. I think Utah dropped off the table for this year. They were -- and New Hampshire had a pending waiver with CMS for an alternative Medicaid expansion plan and that was approved. So those were just a couple of states where their status changed since the last time we met.

So as far as the Medicaid Reform Advisory Group, they've been meeting monthly and as you know, and as we've discussed in the past, have a formidable challenge in the scope of their charge and the amount of time they have to do it. I have included in the very back of Section Two, your handouts for Section Two, the very, very last two documents, just one piece of paper each, a couple of documents that I wanted to share with you.

The first one, the title is -- it's a numbered list, front and back, a list of 23 items. The header is Medicaid Innovation List. It should be in the very back of Section 2, Larry. If you just go all the way to behind -- yeah (affirmative). You're not finding it? Do you have yours? Here, you want to hand (indiscernible - too far from microphone).

This is a list, and I saw we had Deputy Commissioner Christianson here earlier, but I think he must have had to leave. I don't know much about the -- what generated this list, but this is a list that the Department of Health and Social Services presented to the group and I think it's essentially kind of a brainstormed list from Department Medicaid program leadership and so that kind of leadership subteam presented to the Medicaid Reform Advisory Group, this list, at the last meeting, and my sense was that the Advisory Group members recognized that the majority of the items on this list really fall more in the realm of efficiencies, and things that the Department could implement without legislative support and so one of the things they're working on doing is trying to tease it out into two groups, the more kind of general efficiencies that the Department could implement on its own authority, and the other things that might constitute a little bit more significant reform.

In addition to that, they have asked the Department

leadership to come back with more information for them about what each of these items mean. So my understanding now is that the August meeting, which was scheduled for sometime next week, has been cancelled. Is that right, Barb? Barb's been providing the logistical and administrative and technical support for that group while they're meeting.

We're trying to do what we can to help out, and so this month's meeting has now been cancelled to allow time for Department staff to pull some more information together on these initiatives and at the next meeting -- do you remember when that next meeting is or do I have it on here? Yeah (affirmative), September 17th, that's right, and we've got it right here.

I was frustrated enough at their frustration at the last meeting that I talked with the Commissioner about coming before the group to present some testimony to share with them the, just at a general level, the recommendations the Commission has made so far, understanding that our recommendations aren't, for the most part, specific to Medicaid and that we've been looking at the broader system, but to help them by providing them a little bit more -- or at least to give them an idea of what a framework for reform can look like and the framework that we've put together, but in addition to that, and what this second piece of paper is, and this gets back again, I said I was going to flash this state

agency implementation plan up again for another purpose, but pointing back to this, Dr. Hurlburt and I have met with, to start populating this action implementation plan document, had met with Margaret Brodie, the State Medicaid Director, a couple of times and had also met with the Department of Administration and some other staff to start pulling in some of those implementation action plan ideas within our framework to address each of our eight core strategies, and so this draft outline that says, "Medicaid Initiatives that would align with Alaska Health Care Commissioner recommendations," and it's organized, again, around our eight core strategies, drafted -- the draft date, July 30th, is a list of those issues, and I'm going to flush these out a little bit and provide a little more written description for written testimony to share with them about what they might do that would align with Commission recommendations and hopefully, also provide some oral testimony at their next meeting. Yes, Keith.

COMMISSIONER CAMPBELL: Do you get any push-back from making recommendations like this to your peer group?

MS. ERICKSON: I don't know yet.

CHAIR HURLBURT: Maybe (indiscernible - too far from microphone).

MS. ERICKSON: We'll see if I still have a job when we come to our October meeting. I think one of the things that

has not been communicated clearly and not clearly understood, but I think that this group understands is the significance of payment reform.

I think they understand the significance of payment reform and how that needs to be a cornerstone of the recommendation, but I don't know. So at some level, and of course, they're all at different levels in terms of their knowledge and understanding of Medicaid, of healthcare, even.

There are different perspectives and different experiences, but I don't know what any of them really understand, except maybe one or two, what payment reform actually means, and what it looks like, and what it might look like, and so one of the things I might do, from our payment reform, so some of you haven't even had this yet, but from our earlier payment reform learning sessions that we had three years ago, I've put together, at one point, for a presentation, I was invited to make a presentation on payment reform and I thought I might pull in some of that just background information with some diagrams, even, for them and Dr. Urata, the book you had shared with us at the last meeting by Cutter, Cutler, he actually -- he has some diagrams that aren't attributed.

I think he got them from our consultant, but the exact same diagrams that we had in a presentation on payment reform from the professor at Carnegie Mellon, who we were told was

the expert in payment reform, are included in that book and it's about how you can design payment to target, you know, keeping people at the best level of care possible and in the right place.

So anyway, we're -- I'm -- that is where they're at. All of their meetings are public. I think they try to provide a teleconference line so folks can listen in, if you're not able to attend. Barb, do you know where that September 17th meeting will be held?

MS. HENDRICKS: The AARP building in the Frontier Building conference room.

MS. ERICKSON: So it will be in the AARP conference room on the 14th floor in the Frontier Building for the next meeting on September 17th.

MS. HENDRICKS: Eleven to 5:00.

MS. ERICKSON: Eleven to 5:00. So do you have any questions, suggestions? Well, I think with that, if we just want to talk for a few minutes about communication plans, we might be able to wrap up a few minutes early today. So are we ready to move on? Okay, if you have any final questions or comments before we wrap up or you can always follow up with me later, feel free to do that.

So we have, as far as our communication plans, we, of course, have our website. We still continue to have more folks signing up for our list serve and I don't -- I try not

to spam them, but I probably don't communicate quite enough with them, maybe once a month, but I think we've got -- we're up to about 1,500 people who've signed up for our list serve to get information periodically.

I think we're getting more interest and it's evidenced by the reporter showing up. I mean, we do put ads in three newspapers, Anchorage, Juneau, and Fairbanks, at least three weeks and just in the public notice section about our meetings three weeks in advance of all of our meetings, too.

One of the things that I was talking to Barb about doing a month or so ago, wondering whether we should, and this is something that I am just not -- I -- into and don't understand, so that's -- I'm dating myself, and that's social media and wondering if we should set up a Facebook page and Twitter account and I don't even know what those things mean, but we were informed that we're not allowed to do that, since we're part of the Department.

The Department has a Facebook page and a Twitter account and we're allowed to use that. So we might start dipping our toes in those waters, but it will be under the auspices of the Department of Health and Social Service Facebook page, but we could still probably get out some more specific messages. I don't know what kind of following they have and the nature of the followers for those accounts for the Department, but we're going to -- we'll take a stab at that.

Barb's also been working with our public information office on designing some posters and banners that we'll start using at -- as we go to conferences and we might start setting up some exhibit tables at health related conferences when we get invited to present and those sorts of things. Yes.

COMMISSIONER URATA: So if we're going to do this Facebook thing, does that mean I have to have a Facebook thing, because I don't.

MS. ERICKSON: No.

COMMISSIONER URATA: I don't and I don't plan to. Okay.

MS. ERICKSON: No, you don't. It would just be a.....

CHAIR HURLBURT: Congratulations.

MS. ERICKSON: It would just be another mechanism for us to get out in a different form to a different audience, information about what the Commission's doing.

MS. HENDRICKS: A lot of media uses the -- goes on the DHSS Facebook page.

MS. ERICKSON: And so Barb is just saying, since she's not mic-ed, that a lot of media use the Department's Facebook page to keep up with what's going on and to get updates and we could make a special effort, too, to start inviting reporters. It's one thing that I really haven't done much of is reaching out to reporters. They come to me and I haven't gone, actively gone to them, but.....

COMMISSIONER URATA: Our meetings are publicized. So

they're able to come if they find us interesting. It may be that we're not very interesting at this point in time, because we certainly don't have much controversy.

MS. ERICKSON: We had too much at one point and I think that's why I got a little gun-shy about inviting them, but we haven't had too much, the last year or two. Yes, Representative Keller.

REPRESENTATIVE KELLER: I'd just be glad we're talking about this a little bit, but about a year ago now, a guy -- I got to know a guy a little bit from out of state, not up here, and he was saying that he was describing how people are getting their information now and I forget the percentages now, but it was a shocking number of the younger people, it's video clips. It's YouTube, you know, and that is the source of all of their information and we are not very good, I don't think, in, you know, in a controlled setting of government Facebook and Twitter, you know, getting that kind of sound bits out and what it would take, you know, is a decision, I think, by the Commission to -- if we're going to do something like that, and then a contract with somebody that knows what they're doing, you know, to maybe take some of our most poignant points, however you say that, and get some, maybe some clips out there and I think that's completely appropriate from my perspective, but -- thanks.

MS. ERICKSON: Yeah (affirmative), actually, that could

be a really good idea, because -- well, one, we wouldn't be allowed to watch them, because we can't -- we don't have YouTube access through the state system. We're blocked from viewing it, but -- however, it doesn't mean we can't use it and we actually have some really skilled public information officers who've developed capacity to develop video PSAs. We actually won an Emmy award for the -- if you have TV, if -- you may have seen the PSA on safe surrender, the young mom giving her baby to a fireman. We won an Emmy award for that PSA, but they develop it for -- they develop videos for recruitment, for some of the staff where we have lots of shortages, like public health nurses and social workers and those are posted online. So those are a couple of examples, but I bet we could have them produce some short videos and post them on YouTube or on Vimeo for us.

MS. HENDRICKS: Dr. Hurlburt's done (indiscernible - too far from microphone).

MS. ERICKSON: Yeah (affirmative), Dr. Hurlburt's done videos on all kinds -- and commercials and PSAs and all kinds of things.

REPRESENTATIVE KELLER: The -- for me, the discomfort is, you know, are we really into this to, you know, self-aggrandizement and that kind of thing. Well, no, but what I mean is, as a group, I mean, we all think of that. I just want to address it right up front. The -- it's -- you know,

that's the uncomfortable part of what we have to do, if that's the way that people listen and I think that it's okay, you know, for us to do that.

That obviously isn't the point, the point is to get the word out on some of the stuff, but we're going to get it -- may get some accusations, "Hey, what are you doing, you know, advertising for the Alaska Health Commission?" Well, hey, just, you know, my problem is that I believe that this is unsustainable and I think that is government verbiage that the average person doesn't hear, okay, and if -- I don't want to be looking back, myself, in a year or so, when this thing's gone in the ditch, saying, "Why didn't you guys in Alaska Health Commission do something," you know, and I think, you know, I just -- hey, that's why, you know.

COMMISSIONER CAMPBELL: It would help if we were a little more -- if we a little more photogenic.

COMMISSIONER URATA: Speak for yourself.

MS. ERICKSON: Well, I think it's a good suggestion and something -- I mean, I'm imaging real short, just video clips of Dr. Hurlburt and some of you all just sharing your thoughts about some of the issues, the findings, the problems we've identified and some on the potential solutions that we've identified, so it's.....

REPRESENTATIVE KELLER: Or some of the users, some of the patients, I mean.....

MS. ERICKSON: Yeah (affirmative), we could identify other stakeholders to participate. We'll go back, if that sounds okay to you, Dr. Hurlburt, and just at least start a conversation with our folks and see what we might do with their help. Yes.

COMMISSIONER URATA: I don't think we should spend a lot of money on it. So if we can.....

MS. ERICKSON: But that's -- yeah (affirmative).

COMMISSIONER URATA: .....keep it to a small amount, if that's possible, I don't know.

MS. ERICKSON: Well, and that's the beauty of having this in-house expertise. We won't have to go out for a big contract with some outside marketing firm to do it, that it would be -- yeah (affirmative), it should be very reasonable, I would imagine.

REPRESENTATIVE KELLER: You got Deb to do it.

MS. ERICKSON: Barb and I have iPhones, yeah (affirmative). It might be a little shaky. Okay, we've added that to the to-do list. Well, we are at the end of our agenda and we're ready for our wrap-up conversation. Does anybody have any final questions or comments? Did you find that in your notebook?

CHAIR HURLBURT: Yeah (affirmative).

MS. ERICKSON: Well, you keep it and we'll get it. Yes, Dr. Urata.

COMMISSIONER URATA: When are we going to talk about behavioral health, you know, after thoughts about behavioral health? Is that going to be in October?

MS. ERICKSON: Well, we can do that. Do you want to spend it -- since we are ahead of schedule, do you want to spend just 10 minutes on your initial thoughts right now? We could.....

COMMISSIONER URATA: Well, you know -- you know, a lot -- when do we -- when are we going to talk in our organized way about what to recommend, you know, final thoughts about recommendations and.....

MS. ERICKSON: Well, we -- this is an area that we were studying the current conditions. It's not an area for strategies for developing recommendations.

COMMISSIONER URATA: Okay, because I asked them -- that there was, you know, nothing specific that they thought they needed and so they were going to draw up a list and send it to you, so please.....

MS. ERICKSON: Well, they can send us a list of what they need, but it's not an area that we were developing recommendations around.

COMMISSIONER URATA: Yeah (affirmative), then please explain that to them and that I was out to lunch.

MS. ERICKSON: I will do that, but I won't put it in those terms, because you weren't.

COMMISSIONER URATA: That's a figurative term.

MS. ERICKSON: Other questions or comments before we just evaluate the meeting? Do you want to just take a couple of minutes, Dr. Hurlburt, what you liked best and.....

CHAIR HURLBURT: Yeah (affirmative), any feedback, what went well, what could have gone better? We did, in response to request, did return to the day-and-a-half format, which I think facilitates the rest of people's lives, sometimes. So any comments about what went well, enough time for discussion, topics, planning for this meeting? Bob.

COMMISSIONER URATA: I thought the site visit was really -- really went well and was revealing in many ways. I was impressed with the presentation today about behavioral health and what we're doing in our state.

CHAIR HURLBURT: Would you want basically Deb and me to just keep in our minds, we don't want to be a touring group, but if there's another thing that would come up that might be of help in really understanding the whole healthcare sector in our state, to have another tour like that sometime?

COMMISSIONER URATA: Sure, but it depends on, you know, what the value would be and I don't, you know, I think it's hard for us to move to here and have a meeting and then spend several hours looking at something, but you know, I think it's valuable, but I don't think it's -- I think it's kind of a cream type thing, cream.....

CHAIR HURLBURT: Yeah (affirmative).

MS. ERICKSON: Maybe if it's relevant to a particular topic or setting?

CHAIR HURLBURT: Right, and that's why I was kind of tentative. So if there were a unique type opportunity.....

COMMISSIONER URATA: For example, I'm not so sure that visiting API would be valuable.

UNIDENTIFIED SPEAKER: Especially overnight.

CHAIR HURLBURT: Jim.

MR. PUCKETT: I think tours are very beneficial, as long as they are focused. The way I look at a tour is as a teacher, students always want to go on a field trip. They love going on field trips, but they didn't like it when I had a field trip that was very focused. They had a list of questions that they were supposed to answer on the field trip, things of that nature. So I'm not suggesting that Deb write up a list of questions for us to answer when we go on a tour, I'm just saying a tour is good, as long as we know exactly what we're supposed to be looking for and what we are supposed to be learning from it.

CHAIR HURLBURT: Thank you. Was there enough time for discussion?

COMMISSIONER CAMPBELL: Yeah (affirmative), I think so, but I particularly -- or was impressed with the tight agenda, so it was topical and it was -- it fits the format we wanted.

CHAIR HURLBURT: What could be better? This location was very appropriate and facilitated the tour that we had here with the JBER Hospital, but other than that, is this a less convenient location for people? There's no plan to come back here again, but it was available. It was kind of program-related and the price was right, but.....

REPRESENTATIVE KELLER: The technical support is super.

CHAIR HURLBURT: Okay, anything else, Deb? I guess that's all. So thank you all for -- Jim, yeah (affirmative), please.

MR. PUCKETT: Well, somebody did suggest ice cream last time we met.

UNIDENTIFIED SPEAKER: I heard (indiscernible - too far from microphone) was going to bring it.

MS. ERICKSON: Barb, the only complaint we got is we didn't get ice cream like was requested last time. Can we put that on our menu for the Dena'ina Center?

MS. HENDRICKS: Okay.

MS. ERICKSON: Okay.

CHAIR HURLBURT: Okay, thank you all and we're adjourned. 11:39:16

(Off record)

END OF PROCEEDINGS